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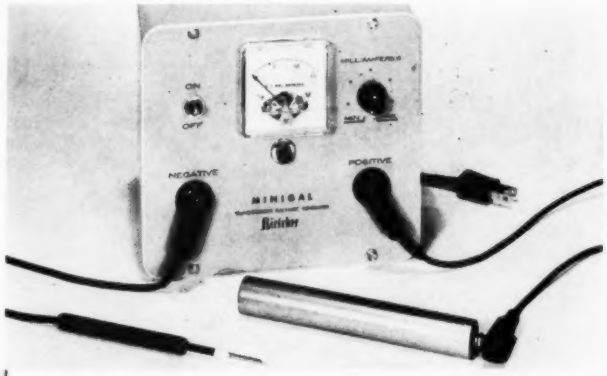

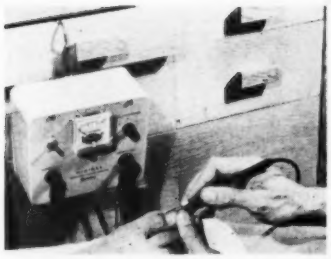

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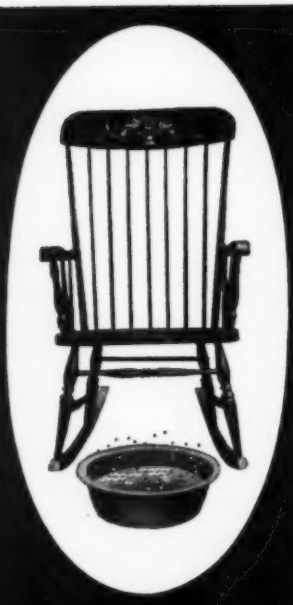

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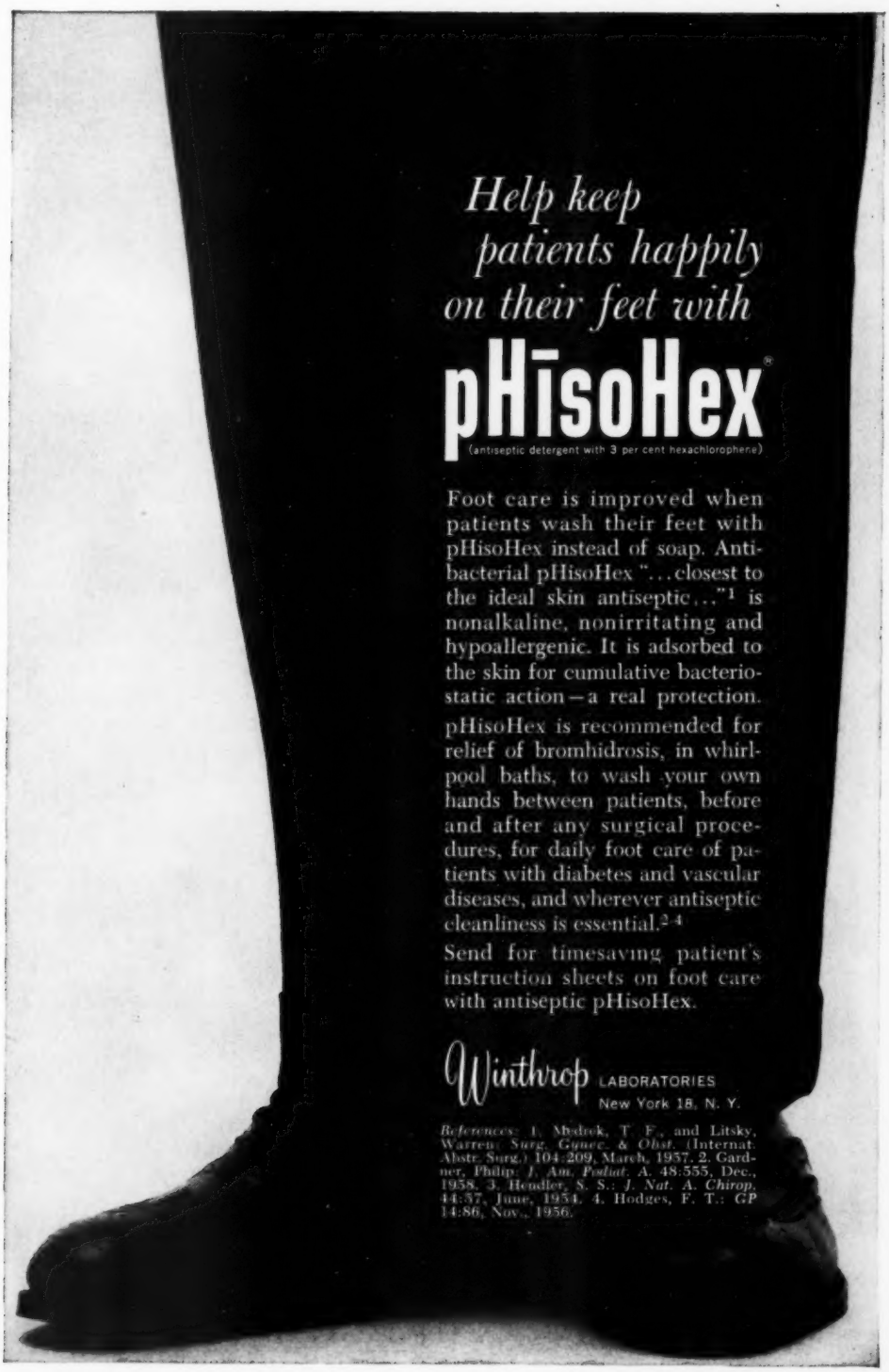
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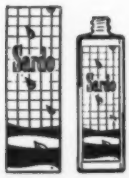

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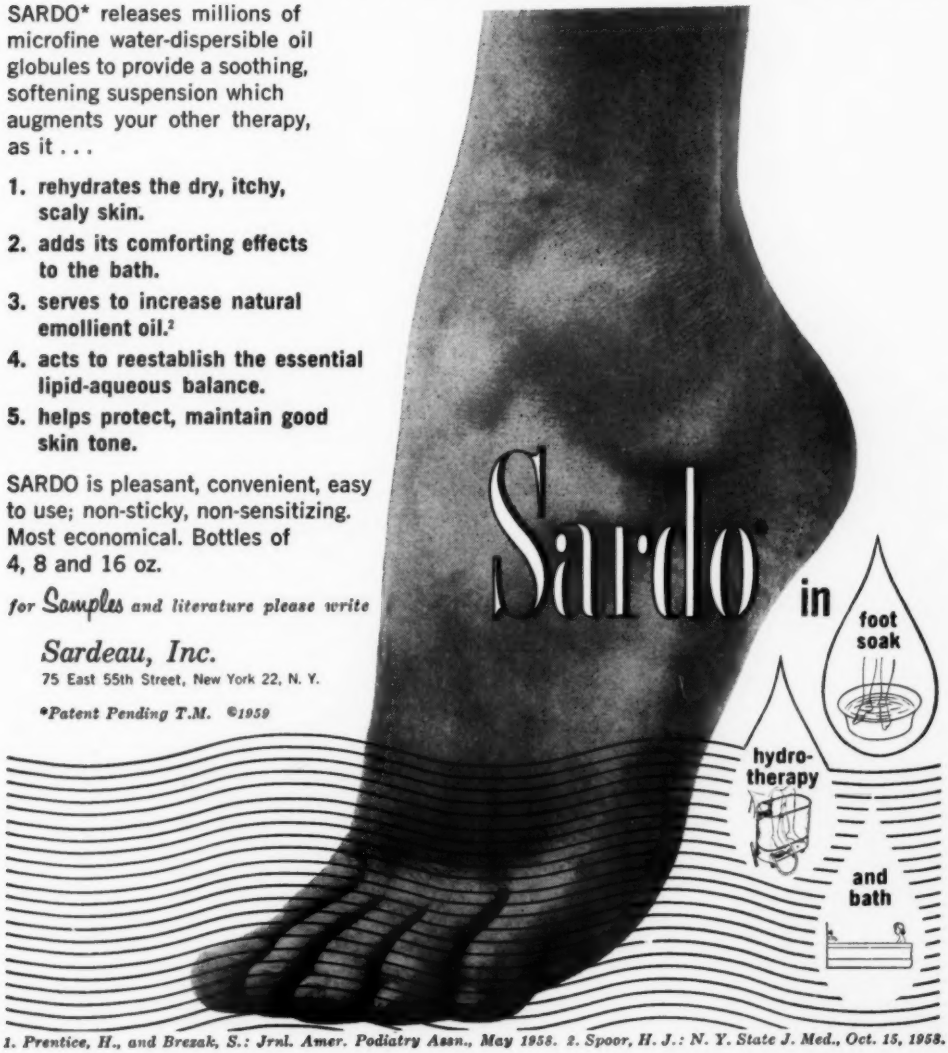

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VOLUME 50 JANUARY, 1960 NUMBER 1

A SHORT REVIEW OF CLASSIFICATION AND ETIOLOGY OF TUMORS*

DANTE CEDRONE, D.S.C.
Cranston, R. I.

WILLIS has defined a tumor or neoplasm as "an abnormal mass of tissue, the growth of which exceeds and is uncoordinated with that of normal tissues, and persists in the same excessive manner after cessation of the stimuli which evoked the change. It is thus to be distinguished from regenerative, reparative and inflammatory processes[1]. Tumors, in the neoplastic sense, are new growths which develop from the propagation of a specific group of cells that are no longer controlled by the general laws of the body and may assume a different structure from that of the original tissue. Since the word tumor in its etymologic sense signifies only swelling, the current usage requires a more strict definition. A tumor, according to present conception, may be erosive and destructive in character and show no swelling whatever. A simple definition is that a tumor is an autonomous, progressive, unlimited new growth, the ultimate cause of which is unknown[2]. A tumor is autonomous due to the fact that it follows its own laws of growth. Its nutrition is derived from the host in which it grows and thus its autonomy is limited. Since tumors derive their nourishment from the blood of the host at the expense of the normal tissues, without benefitting the body in any way, we may say that they act as parasites. The new growth is derived from pre-existing cells and is thus an offshoot from either somatic or germ cells. The cells of the tumor resemble those of the region of origin, but departures from the original type are frequent.

Tumors vary greatly and the possibility exists that no single cause will be found for all. Present studies are largely concerned with the conditions that bring about their growth rather than its primary origin. There are exciting physical, chemical and biological factors which precede the development of tumors in man. These have been experimentally produced in the laboratory with animals.

Tumors have been mentioned throughout recorded history. They have been mentioned in records of India and China dating back to 2000 B.C., and in the cuneiform tablets of the library of Ninevah. They were also described by Hippocrates, Galen and later writers of the Renaissance. Tumors not only affect man, they occur in animals as well.

*A paper in partial fulfillment of Requirements for Certificate of Internship at the Chicago College of Chiropody and Pedic Surgery, 1959.

TABLE I

Differential Diagnosis of Malignant and Benign Tumors

Feature	Benign	Malignant
Capsule	Present	Absent
Recurrence	No	Yes
Blood supply	Poor	Rich
Relation to surrounding tissue	Not adherent	Adherent
Outline	Regular	Irregular
Metastasis	No	Yes
Cells	Adult	Embryonic
Growth	Slow	Rapid
Influence on life	Little	Nearly always fatal

Classification of Tumors

There are many classifications of tumors, but the most important classification from the standpoint of both the doctor and the patient is into benign and malignant forms.

Benign tumors are those which usually grow slowly and are sharply delimited with distinct borders. They have no tendency to spread throughout the body and as a rule they do not affect general health. They should stay small and when arrested from further growth they are harmless. However, if they grow to considerable size, they bring on symptoms by pressure exerted on surrounding organs.

Malignant tumors are those which grow more rapidly and will metastasize into other parts of the body; generally always interfere with health and eventually cause death. Malignant tumors are also more fixed and immovable than the benign. Malignant tumors, when visible, usually bleed with slight manipulation.

As stated above, there are many ways in which tumors are classified. This is due to the fact that each pathologist has his own preferred method of classification (Kulchar). Since there is no standard classification of tumors and no grouping seems entirely satisfactory, for the purpose of this thesis, the simplest and most common classification divides tumors into the following varieties:

1. Tumors of Mesenchymal Origin
   a) Benign
   b) Malignant
2. Tumors of Epithelial Origin
   a) Benign
   b) Malignant
3. Mixed Tumors
   a) Benign
   b) Malignant

DuVries differentiates benign from malignant tumors as in Table I.

Degrees of Malignancy

Broders originated and popularized a method of grading tumors according to malignancy. In this system the tumors are divided into four grades of malignancy as follows:

Grade I—tumors showing greatest differentiation

Grade IV—tumors of greatest anaplasia

Grades II and III represent tumors of intermediate distinctions[5].

Etiology of Tumors

Tumors behave so different from infectious diseases that discovery of a specific cause may be unlikely. As Ewing puts it, the present information indicates that tumors are conditioned by various factors rather than directly caused by them. Furthermore, tumors are a group of neoplastic diseases rather than a single entity. Ultimately, the beginning of a tumor is to be

found not merely in factors which excite cellular multiplication but in something that brings about abnormal, unrestrained, autonomous proliferation[6]. Various theories have been offered as to the independent tumorous growth but none has been established. Studies and experiments on animals and human materials have yielded many important facts about conditions that surround and influence tumor growth. Some apply to a tumor or a group of tumors and not to others. Conditions that work well in experimental animals are not necessarily applicable to man or to other animals. Nevertheless, it appears that the formula, intrinsic factors plus extrinsic factors equals neoplasm, is widely accepted.

Extrinsic Factors

The development of neoplasms in human beings has long been associated with mechanical irritation or injury. In the presence of irritation and injury, cells are killed and new growth tends to replace them. The possible effects of a single injury or frequently repeated injury may excite some hypothetical pre-cancerous condition to neoplasia and cells or groups of cells which have been displaced in embryonal development supposed especially susceptible to growth stimuli, many actively proliferate to form a tumor. In the continued presence of irritating and injurious agent, it is readily conceivable that the cells of the new growth may be altered[7]. However, no proof has been furnished in support of these ideas. Parker and Kernohan found that brain tumor is found as frequently in patients without a history of injury to the head as in those with such a history and that a history of comparable injury is ever more frequent in people who are perfectly well than those with brain tumor[8].

Prolonged irritation has been studied in man and experimental animals for many years and many examples of this relationship exist. For example, the carcinoma of the lip of smokers, carcinoma of the thighs and abdomen of the Kashmiri who use Kangri baskets, and carcinoma of the mouth of Betel nut chewers. The effects of prolonged irritation have been under investigation for many years, but the mechanism of its operation is still unknown. Since the discovery by Yamagiwa and Itchikawa that the repeated application of tar to the skin of mice leads to the development of carcinoma, extensive work along these lines has been done. In 1957, investigators found that anointing the skin of mice with a lanolin solution of methylcholantrene only rarely induced neoplasm; when, however, the same site of skin is anointed with a benzene solution of methylcholantrene the neoplasm occurred earlier and more frequently than in mice not treated previously with methylcholantrene[10].

The influence of small amounts of croton oil applied to the skin of mice for periods up to 83 weeks was tested. After a latent period of 8-10 weeks, papillomas appeared in the more susceptible strains and usually by 20-24 weeks, at least 50% of the mice bore one or more tumors. Carcinoma appeared between 28-34 weeks and the incidence was as high as 25% of the affected total number of mice alive at the time the first malignant tumor was detected. At the end of one year, other strains of mice were tested and found to be less susceptible. The response to croton oil was much greater and the latent period was shorter when the mice had been previously treated with a sub-carcinogenic amount of 9:10 dimethyl and 1:2 benzanthraceine[9].

Viruses

Until recently the only known tumorous lesion in man which was transferred by filtrates was the cutaneous wart. However, not too long ago in a general discussion of the virus theory on the etiology of cancer, the thesis was put forward that carcinogenesis has never been observed in the proven absence of viruses. Recent observa-

tion in the virus field concerning the isolation of cytopathogenic agents from supposedly normal tissues are used to substantiate the arguments. After reviewing the evidence in light of newer knowledge, it is concluded that the viral etiology of certain cancers is an established fact and that viruses are in the cancer field to stay regardless of whether at some future date cancer may be induced by other mechanisms in animals or cells culture proven to be free of viruses[10].

One of the most interesting developments in years concerning the relationship between viruses and tumors is the observation that certain viruses not only inhibit the growth of certain infectious tumors of animals, but actually cause them to regress and disappear leaving behind a solid immunity to the neoplastic disease involved. The most active viruses are certain of the arthropod-borne neurotropic viruses. Some of these viruses have the power to destroy or inhibit sarcoma 180 (an infectious tumor of mice) and/or infectious lymphoid tumor (RPL-12) of chickens and infectious rabbit fibroma. The neurotropic viruses are effective whether inoculated directly into the tumor or at a distant site. The viruses in some respect seem to have a special affinity for the tumor tissues and to infect, grow in, and destroy them. Equally interesting but of still unknown significance, is the observation that after injection of rabies vaccine (a neurotropic virus) into certain patients with malignant melanoma, some of the patients seemed to recover[12].

Parasites

Parasites as a cause of certain tumors in animals appear to act by causing chronic irritation. Little evidence exists that parasites or bacteria are important in human cancer. An exception to this is that Schistosoma haematobium, a parasite common in Egypt, produces chronic irritation in the urinary tract and a high incidence of cancer of the bladder.

Exposure to Sunlight

An important causative factor in many cancers of the skin is the ultra-violet wave lengths shorter than 3200A.

Intrinsic Factors

This term refers to factors that originate within the body as a whole and in those cells which become neoplastic.

The Cohnheim theory presupposes that during embryonal life certain groups of cells are misplaced and subsequently may go on to the production of neoplasms. Presumably they retain the power to grow which is later excited by some unknown factors. In contrast to this theory it is possible that post-natal isolation of cell groups may occur in long standing ulcers of epithelial surfaces and in chronic ulcers of the skin. Epithelial cells become isolated and may grow to produce cancer[13].

Another suggestion is that of Murphy and his associates. They assume that all cells have the potentiality to become malignant and that their growth and differentiation depend upon a balance within them of certain stimulators and inhibitors. They state that the reduction of inhibitors or an increase of stimulator might produce conditions that lead to unlimited growth. There are interesting observations in support of this, but no final proof[14].

Vitamins

It is a well known fact that a lack of vitamin A in the body may lead to various cutaneous lesions. But as yet, none of these lesions have been shown to develop into tumors. Vitamin A is present in tumors and may even aid in the diagnosis of the tumor. A decrease in vitamin A in the body or cells is not a necessary prerequisite to tumor formation[15].

Heredity

Thousands of medical and scientific detectives have been at work throughout the world trying to track down any hereditary factors that may be responsible for tumors.

Studies of twins indicate that hereditary factors are important in determination of comparable situation, type of tumors, and age of onset[16].

Waaler made critical studies of 600 cases of cancer in Norway and found that certain tumors follow a distributional pattern indicative of hereditary factors, but that others do not[17].

As yet, we know only that heredity is directly responsible for just a very few rare types of cancer, not necessarily related to the others, and plays a part in certain additional types that are more prevalent. As Weller puts it in his study of retinoblastoma, it is difficult to determine the exact Mendelian factors and it is likely that predisposition is inherited rather than the tumor itself[18].

Summary

Various hypotheses have been discussed as to the etiology of tumors. Some of the hypotheses are well founded and others are not. A few facts emerge from both the hypotheses and experimental work. The tumor cells possess a totality of characters which distinguish it from its normal form. It becomes an independent structure which departs from normal growth and establishes its own laws of growth. How this change takes place is not clear. However, we assume that the changes are conditioned by various extrinsic and intrinsic factors. The formula, intrinsic plus extrinsic factors equals neoplasm, is widely accepted. This summation of the two factors is not always essential, but it seems to work for most tumors.

27 Pearce Ave.

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And each must make, ere life is flown
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Anon.

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MILTON H. WALKES, Pod.D.
New York, N. Y.

THE treatment of discrete plantar metatarsal hyperkeratosis has always posed a problem for the podiatrist. The many and varied therapies propounded for its treatment are evidence that none of the methods thus far have been uniformly successful in producing a cure from the point of view of function. They are rather based on palliation. It should be understood in this connection that curing a specific lesion, and in so doing causing still another and perhaps even more disabling condition is not the aim of a surgical procedure or of any procedure.

Without doubt, surgical intervention in these instances offers the best hope for the permanent cure of these troublesome lesions which occur most commonly under one of the middle metatarsal heads. The rationale underlying all of the surgical procedures designed to correct this condition involves relief of excessive weight-bearing or an attempt to "normalize" the skin and/or the subcutis. These surgical procedures are best summarized by the four following groupings.

1. Soft tissue procedures for keratosis.
2. Metatarsal shortening by metatarsal head resection or step-down osteotomy.
3. Removal of metatarsal and toe.
4. Plantar condylectomy of metatarsal head.

Comment

1. Soft tissue surgery. In our hands, local excision of the lesion, when it occurs under a weight-bearing surface of the metatarsals, has been unsatisfactory, except in those instances where the keratosis is neoplastic or of infectious origin, as for verruca plantaris. Local excision of the verruca has been an adequate method of therapy in a large percentage of cases. Other soft tissue procedures for the correction of intractable plantar hyperkeratoses include plastic procedures and pedicle grafting as described by Blair[1] in 1937. The specialized function of the skin on the plantar surface of the foot explains our reservations with regard to the results of such a surgical procedure. In addition, if these hyperkeratoses result from excessive localized or pinpointed weight-bearing, then soft tissues procedures can be of no avail.

2. Metatarsal head resection or the "step-down osteotomy" (described by Giannestras[2] in 1954) are procedures which recognize the etiology of the plantar keratoses and are an attempt to correct the pathology. However, in so doing there is removed, either actually or in effect, one of the important weight-bearing points of the foot. The net result is that of impairment of function rather than its preservation and/or restoration. Based on our clinical observations, it is our firm impression that procedures such as stepdown-osteotomy and metatarsal head resection are unnecessarily heroic and fail in one of the prime objectives of any surgical procedure—a good functional result.

3. Removal of the metatarsal and toe, including all the dorsal and plantar soft tissues covering them is a procedure described by Dickson[3] in 1948. The fact that such a radical procedure is employed for the correction of a minor mechanical and functional deformity, emphasizes the problem associated with the treatment of plantar keratosis. This procedure must necessarily be classified with the procedures grouped

as being unnecessarily heroic and physiologically unsound.

4. Plantar condylectomy. The plantar condylectomy as described by DuVries[4] in 1953 is the most acceptable approach to the problem yet described. In our series of 31 cases, the method followed was that described by DuVries with uniformly satisfactory results in relief from the intractable keratosis. However, in 19 of these cases followed for one year or more, 11 developed postoperative traumatic arthropathy in the operated metatarsophalangeal joints. From the point of view of function, this would indicate at least in our hands, that this surgical procedure left something to be desired. It would seem that this arthropathy was a result of one or more of the following factors:

a. Damage to the articular surfaces of the metatarsophalangeal joint by operative manipulation.

b. Excessive fibrosis and capsular involvement.

c. Unpredictable bone callus and repair following removal of the plantar condyles.

Further, it has become obvious that the DuVries procedure fails to take into account metatarsophalangeal joint pathology such as arthritis, luxations and subluxations. DuVries does mention however, that in cases of severe hammertoe the extensor tendon must be sectioned. This, in our experience, has not been adequate, although it is of value.

In evaluating the results achieved with the DuVries plantar condylectomy, we may conclude that this procedure is the most logical and satisfactory approach to the problem of plantar keratosis. Nevertheless, the operation presents certain inadequacies because it does not take other coexisting pathology into consideration and frequently presents undesirable postoperative sequelae.

For a particular surgical procedure to be the method of choice it should achieve not only its immediate objective of alleviating the primary complaint but also an optimal functional result. The conditions which frequently accompany and complicate plantar keratosis other than the involved plantar condyle are not taken into consideration by the DuVries plantar condylectomy. It is necessary to determine the pathologic factors which accompany the plantar keratosis and to devise, if possible, a modification or addition to the surgical procedure which would obviate both the coexisting pathology and the undesirable postoperative sequelae.

The metatarsophalangeal joint is usually involved in some type of deformity when plantar keratosis is present. This involvement may be of varied types, with equally varied etiologies. Relative weakness or paralysis of any of the leg muscles or intrinsic foot muscles which have their action upon the lesser toes must of necessity serve to deform and interfere with the metatarsophalangeal joint by altering the functional position of the toe. These muscles are overlooked as causative factors. Therefore, the "hammered" position of the toes may not necessarily be blamed on the tight shoes or the arthritis, but may be due to the oft-overlooked muscles of the foot and leg and the impairment of the ability of any muscle or muscle group to function properly.

Metatarsophalangeal involvement may also be due to ligamentous and capsular shortening of the involved joint. A shortened dorsal capsule will not permit the proper function of that segment unless the capsular shortening is overcome.

Disease such as the arthritides not infrequently affects this joint and certainly must be considered when contemplating surgical intervention. Simple condylectomy will not improve the status of the joint and may in fact, adversely affect it.

Chronic traumatic luxations and subluxations are also states which should be

considered when procedures on the plantar condyles are contemplated.

It therefore becomes clear that most, if not all, of the conditions which complicate plantar keratosis are conditions in which the metatarsophalangeal joint is involved. As a result of this conclusion the authors have developed a modification of the DuVries plantar condylectomy.

All metatarsophalangeal joint pathologies, regardless of the etiology, have one factor in common. There is limitation of motion at the affected joint, and this limitation is most marked in the direction of plantar flexion. This limitation of motion is frequently accentuated postoperatively in the DuVries procedure by the further dorsal capsular shortening which occurs by normal fibrosis of the tissues following closure, and the incidence of postoperative traumatic arthropathy.

Modification of the DuVries Plantar Condylectomy. A dorsolinear incision is made, medial or lateral to the extensor tendon over the involved metatarsophalangeal joint, extending from mid-shaft of the proximal phalanx, posteriorly to approximately the surgical neck of the metatarsal. Bleeders are clamped and/or ligated. Veins in the operative field are retracted gently or clamped, divided and ligated. The skin is undermined and retracted along with the extensor tendons and the incision deepened in the same plane to expose the joint capsule.

The joint capsule is incised longitudinally and retracted with Allis clamps. The Allis clamps also serve, when closure is to be accomplished, to clearly demarcate the capsule from the surrounding soft tissues. The joint is exposed and the base of the proximal phalanx is grasped with towel clamps. By a combination of careful sharp and blunt dissection, and traction on the clamps, the base and proximal shaft of the proximal phalanx is delivered through the capsular incision. The base of the phalanx is severed by bone-cutting forceps at the level of the junction of the proximal and middle 1/3 of the phalanx and removed. The cut end of the shaft is smoothed by rongeurs and dental file.

The approach to the plantar condyle is simplified considerably. Pressure exerted on the head of the metatarsal upward from the plantar surface and on the toe downward permits direct and visual dissection of the plantar intermetatarsal ligaments from the plantar condyle. These ligaments often interfere with the removal of the plantar condyle.

A closed towel clamp is slipped over the metatarsal head and rests at the surgical neck. Traction on the clamp dorsally and posteriorly permits removal of the plantar condyle with an osteotome and mallet under direct vision. Before the removal of the base of the phalanx was incorporated in the procedure, the removal of the condyle presented a surgical problem, since the cutting edge of the osteotome was not visable after the osteotomy was begun. The condyle is then removed with a pair of thumb and finger mouse-toothed forceps. A Josephs nasal rasp is used to smooth and round the plantar surface of the metatarsal head. Bone chips and filings are carefully picked out of the floor of the joint, and the joint is scrupulously and repeatedly irrigated with sterile saline solution.

The metatarsal and phalanx are repositioned and capsular closure is accomplished with 3/0 chromic catgut interrupted sutures. The tendon is repositioned. Tenotomy is not necessary since the effective length of the tendon is increased by the arthroplasty. This serves to preserve the function of the toe extensors in a now freely functioning joint.

The subcutis is closed with 2 or 3 interrupted 3/0 plain catgut sutures. Subcutaneous closure takes tension from the skin sutures which is ordinarily increased by postoperative edema. This edema when

it occurs in and around the line of incision, where there are tight skin sutures, may account for postoperative skin slough.

The skin is then closed with 3/0 black silk mattress sutures. A dry sterile compression dressing with elastic bandage, the toe held in the slightly overcorrected position, is used. This compression is maintained for about 12 hours. It has been our experience, that with adequate operative hemostasis, compression for a long period is unnecessary and serves to increase the postoperative discomfort.

The patient is non-ambulatory for 48-72 hours with the legs elevated using 2 pillows or shock blocks. Postoperative pain and disability does not seem to be increased at all. Actually it is our impression that postoperative discomfort is lessened by the arthroplasty. This may be due to the ease of operative exposure which makes for less operative trauma during the procedure.

Summary

1. In those cases where operative intervention for plantar keratosis is indicated, the plantar condylectomy is the procedure of choice.

2. A modification of the DuVries procedure is described in this paper which serves to:

   a. Simplify the operative approach.

   b. Overcome those concomitant minor metatarsophalangeal joint deformities which complicate the plantar keratoses.

   c. Eliminate undesirable postoperative sequelae.

   d. Achieve a better functional result.

The perplexing problem of plantar hyperkeratosis was discussed from the points of view of surgical treatment and complicating factors. The DuVries Plantar condylectomy was selected as the most physiologic approach heretofore described. The results of this procedure were analyzed and discussed. Correction of coexisting metatarsophalangeal pathologies as was pointed out were not always taken into account by the operation. A procedure which modifies the DuVries plantar condylectomy was devised and described. The advantages of this modification are outlined.

16 East 79th Street

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COMMON PROBLEMS PECULIAR TO THE FOOT OF THE GERIATRIC PATIENT*

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By definition, geriatrics is that field of medicine which treats all problems peculiar to old age and the aging, including the clinical problems of senescence. In no other single area of the body do the manifestations of age appear so clearly as they do in the foot.

I wish to discuss three clinical manifestations of the aging process which occur in the foot and which are of particular interest to the orthopedist and the podia-

* Read at the Scientific Sessions of the National Association of Chiropodists, Chicago, Illinois, August 19, 1957. *(Ed. Note: Apparently Dr. Kelly's paper was mislaid following the 1957 Annual Meeting. The fact that it was not published was recently called to our attention and a copy obtained for publication at this time.)*

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trist. There are (1) affections of the nerves, or the neurotrophic foot, (2) manifestations of occlusive vascular disease, and (3) infections.

Neurotrophic Lesions of the Foot

Neurotrophic lesions of the foot are most commonly caused by diabetic neuropathy. Unpublished data by Coventry and me revealed that 50 per cent of neurotrophic ulcers seen at the Mayo Clinic are secondary to diabetes. Tabes as a cause of neurotrophic ulcers, although it was the leading cause of such ulcers in past years, now is a rarity, in our experience. Second only to diabetic neuropathy is spinal dysraphism as a cause of neurotrophic ulcers. In this group are such conditions as myelodysplasia and syringomyelia, and interestingly enough, many of our patients who were found to have these conditions were in the fifth, sixth and seventh decades.

Neurotrophic ulcers are most common over the plantar aspect of the forefoot in the region of the metatarsal heads. The plantar medial aspect of the hallux and the tips of the toes also are sites especially susceptible to the development of neurotrophic lesions.

Unquestionably, the decreased sensation in the patient's feet is the prime cause of difficulty. However, a mechanical factor, which is important, also is present.

One is impressed by the broad, splay type of foot with other associated static deformities, such as hammer toes, hallux valgus and prominent metatarsal heads.

The ulcer in question characteristically is punched out. Associated infection and pregangrenous changes often are seen, however. The presence of strong pedal pulses, a normal venous filling time and a favorable response to conservative care rule out the possibility of occlusive vascular disease as a cause.

Treatment

In the care of the feet of the diabetic person, proper control of the diabetes is essential, but equally important is proper footwear. Well-placed pads and bars are essential. Teamwork among the orthopedist, the internist and the podiatrist is essential. Certainly, the elderly patient in many cases responds well to simple debridement of the ulcer, combined with the wearing of good footwear and restriction of activity. In certain cases, resection of the metatarsal head, with or without removal of the associated toe, will yield good results, but always the wearing of good footwear, proper care of excess formation of callus and proper management of the metabolic problem will be necessary.

Manifestations of Occlusive Vascular Disease

Certainly, atherosclerosis obliterans is a common geriatric problem. The foot unfortunately is one area that is affected by this disease. Pain in the foot or calves is the presenting complaint of many of these patients, who are first seen by the clinician interested in the foot. The usual pain which these patients first experience is that of intermittent claudication. The pain of intermittent claudication is described variously as an ache, a pain, a cramp or fatigue developing in the muscle after exercise. Classically, rest relieves this pain. Although characteristically this pain occurs in the foot or calf, it can appear in the thigh, hip or back.

It is paramount that we realize that atherosclerosis obliterans is a segmental disease. Small, segmental lesions in the femoral artery can cause disabling pain in the leg and foot. Results of recent studies by Dahlin, Janes and me in limbs amputated because of occlusive vascular disease have confirmed this impression of the segmental nature of atherosclerosis obliterans. The use of aortography and femoral arterio-

grams is adding to our knowledge concerning small segmental occlusions and intermittent claudication.

My medical colleagues inform me that there is no adequate medical treatment for the patient who has intermittent claudication, and in our hands at least, procedures carried out on the sympathetic nerve pathways have not abated intermittent claudication. Sympathetic block procedures and sympathectomy are of definite benefit in the presence of some ischemic lesions of the foot secondary to occlusive vascular disease when such lesions involve the skin.

At present, in our hands, bypass arterial homografts have yielded promising results in the treatment of certain forms of intermittent claudication. If the lesion exists in the femoral artery, a homograft is routed from the common femoral artery to the popliteal artery, a course which will allow a forceful flow of arterial blood to reach the painful calf and foot. Proximal lesions in the iliac arteries or distal portion of the aorta can be dealt with either by a bypass graft in the iliac arteries, or by replacement grafts in the distal part of the aorta. Of course, all persons who have intermittent claudication are not candidates for arterial reconstruction. It is necessary that their general medical status be such that this procedure would be worth while, and that occlusive vascular disease not be too widespread in the arteries of the legs. Second, we have found that diabetic persons with intermittent claudication are very poor candidates for arterial reconstruction.

Infection

Comment on this third category to which I referred earlier has been included only to mention that group of diabetic patients in whom infection alone is the cause of a distressing lesion of the foot. When any diabetic patient has the triad of occlusive vascular disease, neurotrophism and infection, then infection is a factor that must be managed somehow. If arterial occlusive vascular disease is the paramount factor in this triad, treatment of the infection must be completely conservative. The use of antibiotic agents; rest and foot soaks is the best regimen. The ill-advised performance of minor surgical procedures usually is followed soon by major amputation of the limb.

Comment

It is certainly true that the podiatrist is one of the diabetic patient's best friends. The elderly diabetic person who tries to trim his calluses is taking up the scalpel in what may be the first incision of a major amputation.

There is a small number of elderly diabetic persons in whom arterial vascular disease is minimal. In such an event, adequate debridement, establishment of dependent drainage and the use of antibiotic agents often are very successful. Again, however, it is impossible to overemphasize the value of the approach by way of teamwork. Two clinicians in particular are most able to prevent catastrophe in this group of patients. They are the podiatrist and the orthopedist or general surgeon who is interested in this particular field of endeavor.

Mayo Clinic

"One cannot divide the body into parts for repair as he can an automobile but must treat it as a human being and the treatment given must be the best that the combined knowledge of science can afford."

W. J. Mayo.

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

A SIMPLE METHOD OF FABRICATING A FOREFOOT APPLIANCE FOR HIGH-HEELED SHOES

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THE author has always doubted the therapeutic value of an appliance for high heeled shoes. My doubt stems from the fact that most of the body weight is displaced forward of the metatarsophalangeal articulation to the toes in walking, the amount increasing with heel height. This displacement action gives the doctor very little area in which to work, on the foot or in the shoe in cases of imbalance. Further, if a small balance pad is made for the high heel shoe, it tends to aggravate a painful foot condition, because of pressure from the pad. Another difficulty encountered in most appliances for high heels is that there is very little or no room for them if the shoe is a typical stylish one, and stylish shoes are here to stay as most women prefer them to others for dress.

In spite of the disadvantages of using some types of device in high heeled shoes, the need for it exists. When successive quick steps are taken, the foot is thrust forward causing friction on the plantar metatarsal and phalangeal regions. This can cause the oft complained of burning in the ball of the foot. Also, when the foot is thrust forward, the dorsal toe region is rubbed against the inside narrow toe box, and the resulting friction and irritation may produce corns.

Something is needed to prevent the forward foot thrust which occurs when high heels are worn, and that something can be a toe crest. The devices containing the crest can also incorporate a forefoot balance.

Considerations

There are several considerations to be made. The materials employed should be durable but thin so as not to take up much room in the shoe. It should be of firm substance, because soft yielding materials such as foam rubber compress and require too much thickness to be of any use in high heels. The fabrication should be accomplished with as few materials as possible, that are not messy, and do not require much of your time. The author has experimented with felt, liquid rubber, and wood flour compounds and has found that although the resultant devices work well, there is a "mess," the prosthetic takes up too much room in the shoe, and it is somewhat time consuming for the busy practitioner.

Fabrication

A forefoot, plaster of paris splint, impression is made to obtain the proper size and depth of the individual's toe sulcus or crest. Marking on the foot can be transferred to the impression. The involved areas on the forefoot appliance can be hollowed during the fabrication. Other corrections can be made after the patient has worn the device for some time. (An impression is not absolutely imperative as a functional impression of the toe crest can be obtained after the device has been worn for a time; however, the correct size of the crest is better determined with an impression and the placement made after a functional impression is made on the surface of the appliance.)

Fig. 1. At the right is a bottom view of the impression. Center shows cover leather and korex cut out. Right illustrates the device in a "cut-away" shoe.

The area from the metatarsal bases forward is sufficient or our needs. After the plaster has become just a little firm, the sulcus area (crest area) is gently pushed in with the thumbs to make an indentation. Then a piece of foam rubber 1/8 inch thick is cut and shaped to fit the sulcus. It is then placed in the crest area and the patient stands to create the proper crest indentation upon weight-bearing. The patient is reseated, and the crest area is molded with the fingers, using a little water, to make the impression smooth. Allow to set, remove the impression and mark the outside of the toe crest area.

As the impression is setting, an outline of the insole of the particular shoe in which the appliance is to be worn is made. (Make sure that there is sufficient room in the shoe). If the sock lining is not removable, an outline of the anterior portion of shoe is made, on which a 1/4 inch inside parallel tracing is made, and this is used as the insole outline. This pattern is used to cut out a 1/16 inch thickness of firm korex (combination of cork and rubber). A similar cutout is made of thin white or gray split leather. The cut-out leather and korex are cemented together and placed in the patient's high heel shoes. The patient is instructed to wear the particular shoes as much as possible to produce a weight-bearing and functional imprint. She is appointed for the following week.

When the patient returns, the korex insole is removed, the patient's feet balanced in the usual manner, and she is instructed to return in one week.

The prosthetic is now completed in the following manner. The crest is made directly on the impression. By cutting a small piece of Gauztex®[1] of any width, crumbling it like newspaper and placing it in the toe web area on the cast after a separating media has been applied, you have the base for a toe crest. Thick rubber cement is dabbed into the sulcus area and allowed to seep through the porous weave of the Gauztex. After a sufficient amount of cement is placed into the area, a hot air dryer is used to evaporate excess liquid. The resultant mass is gummy, and should be pressed firm. The toe crest is now complete and it should be allowed to dry for 4 hours. Trim the outlined toe crest.

A functional impression of high heeled weight-bearing is seen on the leather due to perspiration and pressure. Dark spots indicating a tyloma or pressure area can be ground out and a first segment extension pad can be applied to the bottom of the korex. The completed toe crest is now shaped to correspond with perspiration outline on the leather and cemented in place. After the crest is firmly attached,

®[1] General Bandages, Inc.

thumb pressure is used to gently mold the top of the crest to relieve the ridge. (Many molded shoes are not comfortable because the crest is too high or not in the functional position. Care must be taken that the crest does not become a source of irritation.)

Another thin piece of leather of any color is cemented to the other leather. This piece however is not cut and trimmed prior to cementing. After determining the area of break in the high heel shoe, usually just posterior to the first metatarsophalangeal joint, the top covering is cemented to the device while it is being held to coincide with the break of the high heel shoe. The leather is then pressed around the crest area to bring out the toe web and trimmed. A bottom cover may be added if desired. Actually the shoe's sock lining serves very nicely as a top cover because it is thin, has the weight bearing impressions on it, and is already molded to the shoe shape.

Summary

The fabrication of a simple and practical forefoot appliance for use in a high heeled shoe has been described. There is a need for a high heel and "stylish shoe" appliance in some cases. This type of appliance is thin, light weight, durable, and functionally therapeutic. It is custom made and is acceptable by the patient.

309 North Main St.

RHEUMATOID ARTHRITIS
A Case Report

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RHEUMATOID arthritis is an acute or chronic poly-arthritis of doubtful etiology, but possibly of infectious origin. It may occur at any time, but is more common in patients under the age of 40 years. Also, males are more commonly affected with this condition than are females. Though it is still not known whether it is a hemolytic streptococcus or the streptococcus viridans that causes the condition, it is generally accepted that the condition is some form of the streptococcus, since the blood of these arthritic patients contains specific agglutinins for hemolytic streptococci in about 50 percent of the cases[1]. The symptoms of this condition may be acute or subacute in onset, but usually the disease begins insidiously. Ankylosis and deformity are later manifestations of this condition.

Because the onset is usually insidious, it is not unusually mistaken for some other condition. Only after a careful history and examination will guard against such instances. One such case presented itself to me recently which very much resembled a severe pes planus.

The patient was a 46 year white male weighing just under 200 pounds. He was a waiter and bartender by occupation and was consequently on his feet 12 or more hours per day. He complained of severely painful feet and severe pain in the calf muscles of both legs. The severity of the pain was so intense as to make work almost impossible. Upon examination the pulses in both feet and ankles were essentially normal. The feet showed a marked pes planus condition. On palpation there was marked tenderness in the central and medial portions of the plantar fascia and in the calf muscles. The radiographs revealed showed nothing except the usual signs of a pes planus foot. The first treatment consisted of 20 minutes of short wave diathermy followed by a Campbell's rest strap. This gave the patient some comfort, and he was re-appointed for four days later.

At the second visit the patient stated that the strapping had helped somewhat but that the pain was still very severe when standing and even when at rest. Further inquiry revealed that he had just recovered

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from sore throat and that he had some annoying pain in his fingers. With these new findings, a sedimentation rate was performed at once as a rheumatoid arthritic condition was suspected. The results of the blood work-up were: Sedimentation rate –62 mm./hr. (Westergren), WBC–8800, Stabs–8, Neutrophils–66, Eosinophils–4, Lymphocytes–28, RBC–4,630,000, Color Index – 1.1, Hemoglobin – 94.5% (13.8 Gm.).

On the basis of the very high sedimentation rate, a diagnosis of acute rheumatoid arthritis was made and the patient immediately referred to an internist. For relief of pain, codeine sulfate gr.ss one every 3 hours p.r.n. and aspirin 3 tablets every 3 hrs. with milk were prescribed.

The next day, the patient was placed in the hospital by the internist and further tests were made. The diagnosis of rheumatoid arthritis was confirmed.

After the pain was brought under control, Gold therapy was administered by the internist with success. He is now able to work between 4-6 hours without any difficulty. Progress has been very good with this patient and soon he may be able to work a full complete day. Since his occupation is one which puts great stress on the lower extremity, there is still some pain after working, and he also had to return to work sooner, due to economic conditions, than one would wish.

Comment

Too often, a generalized condition such as rheumatoid arthritis will not be diagnosed until the symptoms become more characteristic and acute because of being masked by other conditions, as in this case where everything at the first visit pointed to a symptomatic pes planus due to occupational stress and strain. Only after detailed questioning were further symptoms and signs elicted. It is important to obtain a complete history and suspect other conditions when a condition does not come under control. Early detection of rheumatoid arthritis may spare a patient the agony of some severe remissions (though mild remissions do occur) and deformity and ankylosis so characteristic of this condition may be minimized or prevented.

26 Main Street

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"The memory of Socrates is held in honor for the admirable doctrine he delivered, but Cato's for the glorious deeds he performed."

Cicero

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PRESIDENT'S PAGE

PUBLIC RELATIONS AND PUBLIC EDUCATION

The time has come for a definition of terms. Public relations and education is not—I repeat, is not—press agentry!

Just having many write-ups in newspapers and magazines will not develop, in itself, relations with the public that are needed, nor will this necessarily offer any educational benefits to the public. Outstanding authorities in this field have stated time and time again that when each and every member of our profession conducts himself in a manner that reflects his dedication to his patients, to his community, his colleagues and his profession, then is when our public relations program has begun. When reports of our individual and collective contributions to the advancement of medical science in the field of foot health and care are made, then it can be said we are participating in public education.

A brief search of the record will show that many states, and certainly your own national association, have made a good start in this direction in the past year or two. You have received reports of, and have seen a number of national periodicals carrying the message of foot health and our relationship to it. Your new Audio-Visual Catalogue, also incorporated in your annual Directory, offers a comprehensive list of materials for professional and public education information. The catalogue has been requested by many and distributed to large numbers of editors, hospital administrators and medical schools and libraries. The great many requests by these people and by our members for the materials listed has been very gratifying.

Let us remember that each of us must do our part in our own area. The hired expert can only direct us.

MARVIN W. SHAPIRO, D.S.C.

WHOSE LANGUAGE ARE YOU USING?

People who read a great deal of literature and those of us who have to, are struck by the language used by authors in their reports and dissertations. Each art and science and a subdivision of each, has its own special language. This sometimes makes it confusing and sometimes amusing to readers who are not especially familiar with the area under discussion. A very interesting paper on this subject with respect to medical jargon, the 1958 Oslerian Oration, appears in the British Journal, *Practitioner*, 181:338-44, 1958, by Sir Ernest Gowers.

The discussion of medical jargon by this noted British writer is "confined to its well-recognized meaning of technical terms peculiar to particular pursuits —arts, sciences, professions, trades, games or any other branch of human activity —an esoteric vocabulary not ordinarily understood by outsiders." He quotes a recent writer who advised reading some of the medical books and papers published between 1870 and 1920, adding that "their lucidity and coherence are not simply a gift from the Gods, but the fruit of sweat and toil, of constant rewriting and pruning, until every sentence contained a maximum of clarity in a minimum of words."

Criticism is expressed of medical writing which is pompous, repetitive and makes use of polysyllables when a plain word would do, or use of words with a Latin root to sound learned, or to mystify the patient. Many simple labels are being changed; children's doctors have become pediatricians, skin doctors are dermatologists, ear-nose-and-throat doctors are otorhinolaryngologists; troublesome children have become maladjusted adolescents. The "day he got up" is more easily understood than "the day of ambulation." Saying a patient suffers from intermittent claudication is no different than saying he goes lame from time to time. A condition caused by excessive food intake can be (more simply) the result of overeating.

In this new scientific age former problems solved by common sense must now be approached by the scientific method. "This sometimes seems to consists of laboriously collecting a mass of information in order to prove statistically the truth of something every sensible person already knows must be true and whose truth or falsehood does not matter much anyway." The new sciences require new words for their new concepts. A new piece of esoteric jargon is coined. Vogue words with meretricious attraction drive out those that have served long and faithfully. We no longer have bees in our bonnets; we have complexes. We cannot say we are embarrassed by our mixed feelings; we are suffering from ambivalence. Now no one is shy; he is probably inhibited. We are not affected by our circumstances, but by our environment. We no longer ask a friend what he thinks about some idea; we ask what is his reaction to it. Creeds are now ideologies, heretics are deviationists; we do not ask for forgiveness of sin, but for our unethical behavior. Hardened sinners are now recidivists; we do not try to reform them, we rehabilitate them.

This miasma of verbal abstraction is illustrated by Trilling's comment that people eventually will be unable to say, "We fell in love and married" . . . but will, as a matter of course, say, "Our libidinal impulses being reciprocal, we integrated our individual erotic drives and brought them within the same frame of reference."

Members of the medical profession will not question that the use of such jargon is a widely prevalent disease, that the young are specially susceptible to it, and that it is the duty of those who educate future members of the profession to provide them with every possible prophylaxis; for there is "no calling in which clarity of thought and exactness of communication are more vitally important." Fifty years ago Allbutt wrote in his *Notes on the Composition of Scientific Papers,* "Though composition is painful, the man of science ought best to know that style and matter can no more be dissociated than skin and bone; that if we write clumsily, loosely or disjointedly our thoughts also are undisciplined; for the shifting of language is the weighing of thought and in scientific prose, words should be used as carefully as symbols in mathematics."

AN ENCOURAGING PROGRESS REPORT ON THE PROFESSION'S SUPPORT OF PODIATRY-CHIROPODY EDUCATION

THE House of Delegates at the 1958 Annual Meeting reflecting your interest in providing the necessary funds for the advancement of our colleges created the Fund for the Advancement of Podiatry-Chiropody Education. In January, 1959, the FUND, through a nationwide appeal to all practitioners, augmented the existing educational fund-raising activities of the colleges. Contributions and pledges were solicited in the following manner:

1. They could be sent to the Fund office at our Washington Headquarters and earmarked for a particular college or indicated for a General Fund.
2. They could be sent directly to a particular college where they would be received by the Educational Foundation of that college.

As we complete our first year and start our FUND Campaign for 1960 we can report the results for 1959 shown in Table I.

The $43,032.98 accounted for during 1959 represents contributions from 1073 practitioners, patients, friends and commercial firms. This represents an average contribution of $40.16. In 1958 the American Medical Education Foundation reported contributions of $4,154,450, or an average contribution of $39.58. It should be noted for each of the past two years the Miller Shoe Company of Cincinnati, Ohio, has contributed $1,000 to the Shoe Therapy Department of each school as a salary grant. The above total includes their contribution this year of $5,000.

Recently requests from three colleges totaling $3,505.00 have been made. Two have been processed and grants made and the other is presently being processed. These grants represent ALL the contributions to the Fund earmarked for those institutions. The By-laws of the FUND allow for the use of up to 15% of the General Funds only for administrative expenses and to date only $190.38 has been spent for this purpose. No part of funds earmarked for colleges may presently be used to defray administrative or other expenses of the fund. A 2/3 majority vote of the Board of Trustees is required to alter this present position and our institutions will be notified if such action should be contemplated. These grants to the college are to provide support for salaries of full time faculty personnel in the basic sciences and to assist in the purchase of sterilization equipment, kitchen equipment, x-ray equipment and the furnishings of hospital bedrooms.

It is vitally important that you support your 1960 FUND Campaign. Each issue of the JOURNAL contains a pledge form which you may use for your contribution

and pledge—it may be found on page 14 of this issue. Contributions by every practitioner must be made on an annual basis if we are going to reach these goals.

MORE THAN $3,000,000 NEEDED BY 1965

Our colleges need more than $3,000,000 by 1965. The following demonstrates the multimillion dollar needs of our colleges and remember, these are the *minimum* requirements for buildings, equipment and salaries. For optimum expansion and research, still more money will be needed.

About $3,409,193 will assure adequate education for future podiatrists-chiropodists. Will you help by giving $100.00 in 1960?

Building & Equipment Funds Needed	$4,787,349
Estimated Funds Available	303,500
Minimum Additional Funds Needed	3,120,849
Estimated Annual Teaching Costs	478,000
Funds in Sight on Basis of Enrollment Similar to Present	189,656
Additional Funds Needed Annually to Pay Teachers	288,344

TABLE I

Reported by the FUND

	Total Pledged	Total Received
General Fund	$3,579.70	$2,919.70
California College of Chiropody	2,310.00	1,390.00
Chicago College of Chiropody	1,597.00	1,012.00
Illinois College of Chiropody	2,328.00	1,323.00
M. J. Lewi College of Podiatry	6,117.00	2,854.50
Ohio College of Chiropody	1,357.00	877.00
Temple University School of Chiropody	1,420.00	1,307.50
	$18,708.70	$11,683.70

Reported by the Colleges

	Total Pledged	Total Received
California College of Chiropody[1]		$2,032.50
Chicago College of Chiropody		2,106.75
Illinois College of Chiropody[2]	$66,184.78	20,927.03
M. J. Lewi College of Podiatry		4,052.00
Ohio College of Chiropody[3]	19,356.00	2,231.00
Temple University School of Chiropody[4]		
	$85,540.78	$31,349.28

Totals Reported by the FUND and the Colleges

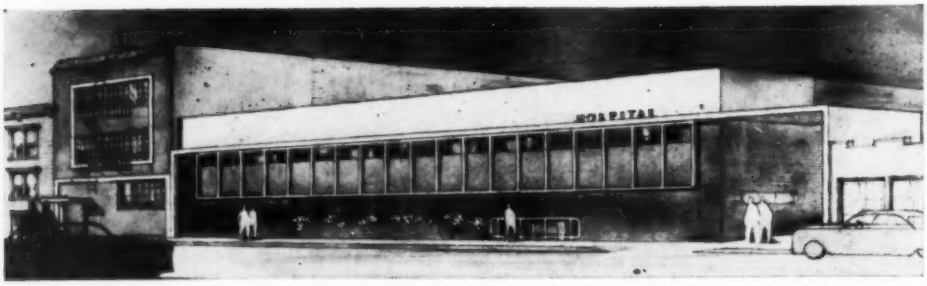
Total amounts	$104,249.48	$43,032.98

[1] Does not include $88,000 contributed since 1945 which was spent during 1959 for the new hospital adjoining the college.

[2] Total amount pledged and received during 1959.

[3] Total pledged over the past few years. Total received is $16,805, of which $2,231 was received in 1959.

[4] Of funds totaling $42,000, many contributors have already transferred their contributions to the Building Fund of the Chiropody Alumni Association.

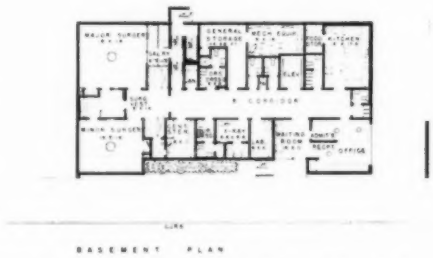


Those who have contributed during 1959 should renew their pledges for 1960. Those who have not contributed should fill out and mail their pledge form today. All pledges will be acknowledged and notices of pledge payments will be sent to you. This is not a charitable contribution—it is an investment in the future of your profession. Cooperate with your state society's FUND Chairman. CONTRIBUTIONS TO THE FUND OR THE COLLEGE OF YOUR CHOICE ARE TAX DEDUCTIBLE.

To give you some indication of the good use that is and will be made of these funds, we have asked the colleges to submit information on their plans and programs for the future. Some of these are described below and others will appear in future issues of the JOURNAL.

California College of Podiatry Hospital Fund

The Podiatry Hospital in connection with the California College of Podiatry is expected to be completed in March, 1960, at a cost of $310,000. The new hospital will accommodate 1,000-2,000 inpatient surgical cases yearly and approximately 20,000 outpatients through its clinical facilities. The plans include such conveniences as air conditioning, modern elevators, the finest room facilities for patients, and up-to-date kitchen provisions. There will be two completely equipped modern surgeries, the latest in diagnostic and x-ray laboratory facilities, as well as full facilities for hospital personnel. The two-story structure started in August, 1959 is located at 9 Farren Street, San Francisco 15, California, on adjacent land acquired by the college.



California College Podiatry Hospital

Illustration across the top of the page is the architect's project of the podiatry hospital now under construction at the California College of Podiatry. The center and lower illustrations are floor plans of the first floor and basement of the hospital.

Chicago College of Chiropody

Realizing that only with the cooperation of a great many people can the school contribute all that it has to offer its students and the profession, committees have been appointed for all the major areas of activity of the school, to study the programs as presently offered, to attempt to recognize both weak and strong areas and to create recommendations for carrying forth each individual program towards fulfilling the objectives of the school. Further, each group will function as action committees in that after acceptance by the Executive Committee these committees shall then carry into being their own proposals. The Steering Committee, which will keep our project alive, functions within the Executive Committee, whose purpose is to receive, correlate, accept for suggested action, reports and recommendations. Even in the short time it has taken to formulate the committees, suggestions of remarkable interest and insight have come forth. Other committees are: Curriculum, Clinic, Extension, Development, Alumni, Library and Bibliographic, Research and Scientific, Scholarship, Women's Guild, Student Affairs, Scholastic.

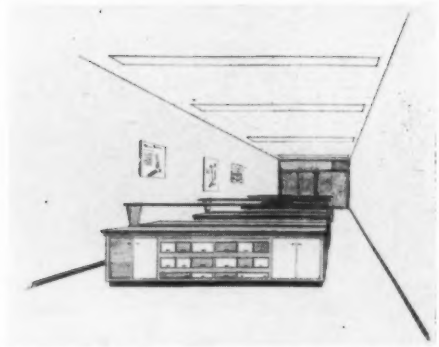
From the standpoint of instruction, we feel we are already making strides by adding more medical doctors to our clinical attendance and instruction. We obviously need more, as all schools do, full-time teaching personnel who are students in the true sense of the word, who will study and teach and do research for the pure joy of it. These men must be chiropody oriented, and have a deep feeling for the profession. Our hope is to hold our better graduates for teaching and clinical work, and at the same time, to pay their tuition and other school costs for continued study towards advanced degrees. From this we would hope to collect around us well versed individuals who can give us back their knowledge.

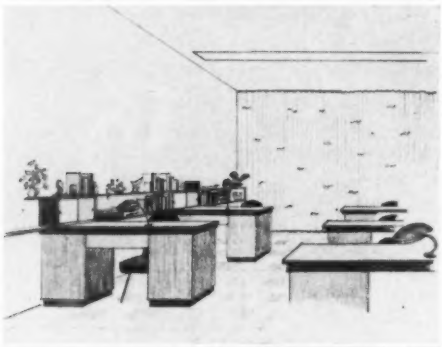
We feel one of the important additions for better training and progression of the profession is a college attached hospital for which we are now laying plans.

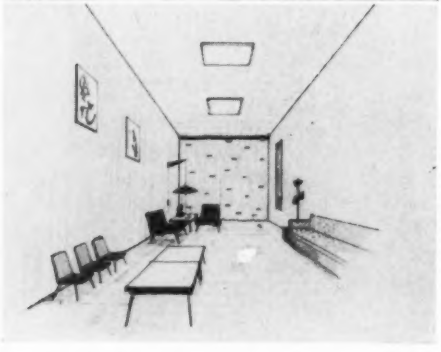
Illinois College of Chiropody and Foot Surgery

Through the Alumni Education Foundation, funds are being provided solely for the support of teaching and research; to make possible the addition of outstanding teachers to the faculty; to provide the organization and machinery by which scientific discoveries, inventions and processes may be developed, applied and patented, and by which utilization and disposition of such patent rights that may accrue, as may be of benefit to mankind or as may tend to stimulate, promote and provide funds for teaching and research within the College.

A new look will be evident in the entire neighborhood surrounding the school. Most of the old buildings from Division Street to North Avenue on Clark and LaSalle Streets are being razed and replaced by modern apartments. The 1317 North Clark Street building owned by the College will be razed. Present plans include the building of a locomotor rehabilitation center and the establishment of hospital facilities on the 1317 premises. Our development plans also include the establishment of full-time laboratory personnel. This will facilitate improved laboratory instruction and provide opportunities for more and better research. Within the past two years Physiology and Biochemistry Laboratories have been established in addition to the Histology, Bacteriology, Anatomy and Chemistry Laboratories. More full time personnel is imperative if we are to make the best use of our facilities.







Ohio College Building Program

In the column to the left are architect's drawings of presently planned physical additions to the Ohio College of Chiropody. From top to bottom these are: physiology lab, faculty study, library and faculty lounge.

Ohio College of Chiropody

On the occasion of the most recent Commencement a new modern senior classroom, provided by the Alumni of the Ohio College of Chiropody was dedicated. Architectural drawings of additional planned facilities are pictured below. A laboratory for physiology will be the first of several which are planned. The present library will be expanded and the planned Faculty Study will provide facilities for student consultation.

Chiropody Alumni Association of Temple University

Temple University reaffirmed its position to discontinue the School of Chiropody as part of the educational program of the University after classes currently enrolled are graduated. Temple University, however, is cooperating fully with the Chiropody Alumni Association in their efforts to establish an independent school or clinic. Such cooperation will involve the transfer of all equipment that pertains to the chiropody program to the new school and the encouragement of contributors to the present Chiropody Building Fund to transfer their contributions to the Chiropody Alumni Association.

Following this decision by the University, the Chiropody Alumni Association made a formal proposal to St. Luke's and Children's Medical Center of Philadelphia for the establishment of a new school of chiropody as an affiliate of that institution. At a meeting of the Board of Trustees of St. Luke's and Children's Medical Center held in June, 1959, our proposal was accepted and formal negotiations toward the

erection of a new school of chiropody in Philadelphia were initiated. The Chiropody Alumni Association is indeed deeply appreciative of the efforts of James C. Giuffre, M.D., Medical Director of St. Luke's for his enthusiasm and support. Under plans of the Philadelphia Redevelopment Authority there will be a condemnation of many old buildings in the immediate vicinity of St. Luke's and this ground will be turned over to the hospital for new buildings, etc. A portion of this ground has already been plotted for a new building to house the new school of chiropody.

Following this development, the first project was to inquire into the necessary requirements for receiving a charter to grant the degree of Doctor of Surgical Chiropody. Cooperative efforts are being made by the Chiropody Alumni Association and the Board of Trustees of St. Luke's and Children's Medical Center to the Department of Public Instruction of the State of Pennsylvania towards this end. While the charter must be granted before any official fund raising campaign can be started, the Chiropody Alumni Association is hopeful that this will be accomplished in the very near future. Preliminary architectural drawings on the physical plant to house the school of chiropody have been made. Professional fund raising agencies, for the management of the raising of monies required for this project, are presently being interviewed.

The establishment of a school of chiropody with a high ranking medical institution in Philadelphia should not be confined to local interest. It is a profound forward movement for the profession and should be focused on a national level. The groundwork is now being laid in Philadelphia and once the program has been fully projected it will be of vital interest to the entire profession. The Chiropody Alumni Association is hopeful that this will be a national movement rather than a local one.

PLEDGES AND CONTRIBUTIONS TO THE FUND FOR PODIATRY-CHIROPODY EDUCATION

The following have made a contribution or pledge to the Fund, or directly to a college or its Alumni Foundation. Code for letters following individual names shown below:

ICC—Illinois College of Chiropody
CaCC—California College of Chiropody
ChCC—Chicago College of Chiropody
OCC—Ohio College of Chiropody
TUSC—Temple University School of Chiropody
LCP—M. J. Lewi College of Podiatry
GF—General Fund
NYSoc—The Podiatry Society of the State of New York.

CONTRIBUTIONS TO "FUND"

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Anonymous LCP
Anonymous GF
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Dulla Pharmacy GF
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Eads, William F. CaCC
Ehrlich, Henry GF
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Eschbacher, Paul R. CaCC
Evans, George J. GF

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Farrar, Mr. C. N. GF
Field, Donald W. CaCC
Flaxman, Eugene R. ChCC
Forgea, Mrs. Margaret GF
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Frank, S. C. LCP
Freigenberg, Seymour LCP
Friedman, Bernard E. LCP

Gaylord, Chesley N. CaCC
Gennis, Milton H. ChCC
Goldberg, H. C. GF
Goldschmidt, Alexander LCP
Goldstein, M. C. NYSoc
Gorman, B. R. LCP
Gould, Frank LCP
Graf, Albert LCP
Graham, John ICC
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Green, John E. LCP
Green, Walter LCP
Greenberg, Frank LCP
Greenberg, Leo GF
Grossman, Murray LCP
Grossmann, Milton LCP
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Guy, Joseph GF

Haas, Morris ICC
Hall, Vern S. ICC
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Hilton, A. L. GF
Hogan, Gerald D. GF
Horn, George LCP
Horowitz, Harry and Sylvia NYSoc
Hoyle, Mr. James O. GF
Hymes, Leonard TUSC

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Illinois Association, Zone III ICC-ChCC
Iowa Liquid Rubber Appliance Laboratory ICC-GF
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Ivers, Miss Catherine B. GF

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Junod, Mr. John A. ICC
Junod, Mr. Paul D. ICC

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Katz, Samuel CaCC
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Kilander, Martha GF
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Lefrak Foundation, The Joseph GF
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Luper, David and Nathan LCP
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Marks, Irving L. NYSoc
Matisoff, Nathan LCP
McCormack, F. J. LCP
McGlamry, E. Dalton TUSC
McMahon, Mrs. John B. LCP
McRae, O. B. GF
Meinecke, R. ChCC
Michetti, Armando LCP
Michigan Association, Wayne County Division (In memory of S. K. Richardson) GF
Michigan Association, Wayne County Division (In memory of Mrs. Sarah Thome) GF
Michigan Association, Women's Auxiliary GF
Morris, Jonas C. GF
Mullens, Benjamin C. NYSoc
Mullnix, Arthur ICC
Murray, George A. GF

NAC Agency GF
Nelson, Pierce B. CaCC
New Hampshire Association GF
Newman, Maurice C. LCP
Noffsinger, Mrs. Maude GF
Nyman, S. P. GF

Orr, H. W. OCC
Owens, Ralph E. ChCC

Pankratz, John C. ICC-OCC
Perendy, William ICC
Perez, Antonio P. LCP
Pincus, Albert TUSC

Rakow, Martin A. LCP
Ransom, Mrs. GF
Rasmussen, David C. GF
Ricker, Mrs. E. M. GF
Riddle, A. C. TUSC
Riley, John H. ICC
Robbins, Mrs. H. GF
Rock, James L. LCP
Roddy, Marion E. CaCC
Roggenkamp, O. E. ICC
Rosen, Maurice LCP
Rosenfeld, Hyman ChCC
Rosoff, Samuel GF
Ross, Mrs. Prentiss GF
Ruggiero, F. J. ICC

Sabia, Michael L. LCP
Salinger, Edward CaCC
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Saperston Laboratories GF
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Shapiro, Marvin W. OCC-GF
Shelton, Lacy R. OCC
Shor, Robert CaCC-ICC
Shore, George A. CaCC
Shyne, Mrs. F. GF
Simko, M. V. ChCC
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Sluzewski, Alfreda J. ICC
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Snyder, Mrs. Clara ChCC
Snyder, Irving R. GF
Sollod, Alvin J. TUSC
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Somers, Mrs. R. H. GF
Spector, Wilfred M. ChCC
Spinelli, John A. OCC
Spreadby, Marian L. GF
Starr, Joseph L. GF
Steiner, Joseph W. LCP
Sterrett, Anthony H. LCP
Stevens, Harold LCP
St. John, Mrs. H. Blake GF
Stradling, Miss Gladys GF
Strong, Peter E. GF
Sudel, Mrs. C. J. GF
Sullivan, Joseph D. CaCC

Takata, Miss Yo GF
Teitel, Milton L. LCP
Teves, Arthur R. ICC
Toepp, Frank C. ICC
Tortora, Michael J. LCP
Turchin, Charles R. LCP-TUSC

Varzos, Peter N. ICC
VonDraska, D. R. CaCC

Walton, Miss Gladys GF
Weinberg, Joseph OCC
Weiner, Mrs. David GF
Weiner, Ernest NYSoc
Weiner, Harold LCP
Weisberger, Eugene OCC
Wells, J. K. ChCC
Wentz, Mrs. Clara GF
White, H. R. F. LCP
Wilson, Ray ChCC
Wittenberg, Morton GF-ChCC
Wolfson, Milton NYSoc
Wolstein, Arthur LCP
Wunderlich, Charles H. ChCC
Wunderlich, Erwin F. GF

CONTRIBUTIONS TO COLLEGES

(As reported to "Fund")

Abernethy, Carroll G.	ICC	Blood, M. L.	ICC	Chasin, E.	LCP
Abernethy, Coyte G.	ICC	Bloom, Eluh	OCC	Chernin, Jack	OCC
Abernethy, J. Lloyd	ICC	Board of Trustees,		Chiropody Supply	
Abernethy, Lee D., Jr.	ICC	Dr. A. G. Roos	CaCC	Headquarters	ICC
Abrams, L. H.	OCC	Bodian, H. B.	LCP	Churchill, A. B.	ICC
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Alexander, E. J.	OCC	Bordelone, Manuel	OCC	Cohen, Gerald	ChCC
Alexander, Raymond	OCC	Borovey, Mathew	OCC	Cohen, Irving I.	ICC
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Altman, D.	LCP	Brachman, P. R.	ICC	Colela, A. J.	OCC
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Council	LCP	Brahms, Malcolm	OCC	Collett, John B.	ICC
Anderson, B. L.	OCC	Brain, Robert	OCC	Collins, H. L.	OCC
Anderson, Emma	CaCC	Brancel, Doris K.	ICC	Collins, Wayne B.	CaCC
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Applebaum, A. S.	ICC	Brennan, R. L.	ICC	Conserva, Donald	OCC
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Arizona Chiropody		Brightwell, James T.	ICC	Cook, Doyle	OCC
Association	CaCC	Brittain, James A.	OCC	Cook, William H.	ICC
Arnold, Alfred	OCC	Brodie, David	OCC	Cooley, Rosa L.	ICC
Bachelor, D. F., Jr.	ICC	Bromberg, M.	ChCC	Cooper, Carlos	OCC
Badger, Lincoln	OCC	Brooks, Harold M.	ICC	Cooper, Lon	OCC
Badke, W. J.	ICC	Brooks, J. E.	ICC	Cope, Jean	OCC
Baker, Francis M.	ICC	Brosky, Bert	OCC	Cope, William	OCC
Bakst, Myron	OCC	Brown, Edith M.	ICC	Copeland, Q. E.	ICC
Baldwin, J. T.	ICC	Brown, Irma A.	OCC	Copp, Harry	OCC
Balkin, S.	ChCC	Brown, Joseph F.	ICC	Corp, Blaine	ICC
Barga, John E.	OCC	Bruno, Frank	OCC	Coss, Harry	OCC
Barnes, J. H.	ICC	Bruno, Leon	OCC	Cotter, Harry, Jr.	OCC
Barnhart, William	OCC	Bubenhein, H. Joseph	OCC	Cowell, D.	ChCC
Barre, V. K.	OCC	Buchan, J. H.	OCC	Cox, Forrest H.	OCC
Barrock, A. Edward	ICC	Buchan, Robert	OCC	Cox, Reid L.	ChCC
Bartell, C. A.	ICC	Buchbender, Arthur	OCC	Crotty, Thomas	OCC
Bartig, W. R.	ICC	Buchbender, Edward	OCC	Crutchfield, Allen	CaCC
Beach, C. P.	OCC	Buckrop, M.	ChCC	Cummings, Milton	OCC
Beasley, Charles W., Jr.	ICC	Budak, George	OCC	Curson, Huber	OCC
Beer, Adam	OCC	Burke, Rosalie	OCC	Cutrell, C. G.	ICC
Beghardt, Jack	CaCC	Burkhead, Harold R.	CaCC	Dahl, G. Conrad	ICC
Behrends, Robert L.	ICC	Burleson, Thomas E.	ICC	Dahl, G. C.	ICC
Benedict, Edward	OCC	Burton, R. F.	ICC	Damiano, Frank	OCC
Bentley, John A.	ICC	Bushbeck, E.	ICC	Davidson, Philip	OCC
Berenson, R.	CaCC	Bushbeck, W.	ICC	Davis, J.	ICC
Bergen, Sidney	ICC	Butler, Mrs. B. A.	ICC	DeCarlo, Michael	OCC
Bergman, M.	ChCC	Byrne, C. W.	CaCC	Deffinger, T. L.	CaCC
Berk, Meyer	OCC	Cain, Dellworth L.	ICC	DeFino, P. J.	OCC
Berkin, Louise	CaCC	Cain, John W.	ChCC	DeLeo, Dr. & Mrs. A. J.	CaCC
Berkowitz, M.	LCP	Caldwell, Virgil	ICC	Deneke, Kenneth	OCC
Bernzweig, S.	LCP	Calligro, M. V.	OCC	Dennis, Henry	OCC
Berry, Irving	LCP	Cameron, Donald J.	OCC	Dennison, Donald W.	ICC
Bertram, R. O.	OCC	Caneva, Reno	ICC	Diamond, L.	ChCC
Bevilacqua, Joan	OCC	Caplowe, Samuel	OCC	Diamond, Louis	ICC
Beylin, W. L.	OCC	Carby, J. W.	ICC	Diamond, L. W.	OCC
Bialow, Murray	OCC	Cardy, Donald K.	ICC	Difenbach, E.	CaCC
Bianco, Nicholas C.	ICC-OCC	Carnes, Robert R.	ICC	Dikran, Rosalie	OCC
Bielmaier, E. B.	ICC	Carnevale, A. R.	LCP	Dill, Howard M.	ICC
Bishop, Leo J.	OCC	Carnow, J.	ChCC	Dinda, Andrew	OCC
Bittenbender, C. R.	ICC	Caron, F. Evans	OCC	DiPiero, H. H.	OCC
Blaskinski, Walter M.	ICC	Carr, Eugene	OCC	Dixon, M. K.	OCC
Blass, M. J.	LCP	Caster, Frank	OCC	Dodson, Douglas D.	CaCC
Blau, Kurt	ChCC	Cena, John P.	OCC	Dolinger, George	OCC
Blau, S. H.	ChCC	Cerroni, Lawrence J.	ICC	Doller, J.	ChCC
Bliehall, Donald F.	OCC	Chapel, Herman	OCC	Donahue, William	OCC

Donoho, O. R. ChCC
Donohue, E. F. ICC
Dorsey, Edward W. ICC
Dotto, Rose Z. OCC
Douglass, Paul OCC
Ducote, A. Avit ICC
Duncan, Paul E. ICC
Dunn, W. Grady OCC
Dunshee, C. B. ICC
Durant, Jack OCC
Durkin, Edward ChCC
Dustan, A. S. ICC
Duvries, H. L. ICC
Dyer, Duane CaCC
Edwards, Blanche OCC
Edwards, Thomas OCC
Egerter, B. C. OCC
Eling, John C. OCC
Ender, C. G. ICC
Erdmann, G. E. ICC
Erickson, E. P. OCC
Erman, J. J. OCC
Evans, Richard D. ICC
Eyer, Glenn OCC
Falknor, Gordon ICC
Faloon, Kenneth ICC
Farrell, W. Lynn ChCC
Fauth, D. ChCC
Favenesis, E. ChCC
Feazel, Eugene F. ICC
Feder, H. J. ICC
Feinberg, Herbert ICC-OCC
Feldman, Dr. & Mrs. Morris CaCC
(In memory of Emanuel Ragghianti)
Feldman, Raymond OCC
Fenton, Henry OCC
Ferrier, Louis J. ICC
Fields, Frank C. CaCC
Fields, Ronald OCC
Findley, Chester H. ICC
Fine, W. W. OCC
Finnegan, W. P. ICC
Fishbein, J. C. ICC
Fisher, Carl B. OCC
Fisher, Carlman OCC
Fishman, Leonard OCC
Fitzgerald, Paul LCP
Fladger, C. B. OCC
Flambaum, Edward OCC
Fletcher, J. D. OCC
Fletcher, T. J. OCC
Flynn, James H. OCC
Foote, John E. OCC
Ford, Robert OCC
Fordyce, O. F. ChCC
Forney, W. S. OCC
Foster, Herman ICC
Fotre, Harold ICC
Fowler, Ralph OCC
Franden, Jack E. ICC
Frank, I. H. OCC
Frankel, Nathaniel OCC
Frankson, John E., Jr. ICC
Franson, Wilbur J. ICC
Friedel, A. W. ICC
Friedel, C. M. ICC
Friedman, Oscar H. ICC
Frisch, William J. ICC
Froehling, W. ChCC
Frost, Floyd W. OCC
Fugett, A. M. ICC
Funston, Joseph OCC
Gamble, Felton OCC
Garcia, D. J. ICC
Gardner, Philip CaCC
(In memory of Fanny Crostwait)
Garrett, Alvin OCC
Garrett, William H. ICC
Gartner, Herman F. ICC
Gartner, Leo G. ICC
Gartner, Wilfred R. ICC
Gearhard, William N. ICC
Gebhardt, Dr. & Mrs. J. F., Jr. CaCC
(In memory of Mr. R. Barrett, Charles Blyth, and Mrs. Ludlow)
Gellenbeck, E. D. OCC
Gennis, M. H. ChCC
Giannini, J. N. ChCC
Gibbons, S. W. ICC
Giese, Edward L. ICC
Giudice, Robert OCC
Glauber, James H. ICC
Glidear, Nathan ICC
Glockner, R. J. OCC
Goldhamer, Irving CaCC
Goldman, A. H. ICC
Goldstein, Samuel OCC
Goldsworth, Harry OCC
Goodman, Willard OCC
Gottler, S. Robert ICC
Grabeau, Ellis OCC
Graham, John R. ICC
Graves, G. M. OCC
Gray, Howard OCC
Green, Murray OCC
Greenberg, Sam ICC
Greenfield, M. M. OCC
Greenwald, Joseph ChCC
Greiner, Charles OCC
Greiner, Harry OCC
Grossman, Nathan OCC
Grown, Joseph ICC
Grudowski, Nell & Joseph P. ICC
Grund, Frank ChCC
Guenzler, George ICC
Guthman, H. C. ICC
Haas, Morris ICC
Hack, Lee R. ICC
Hadden, H. E. ICC
Hadkin, A. ICC
Haglund, R. A. ICC
Haidle, James OCC
Haigh, G. F. OCC
Hale, Scott K. ICC
Hall, V. S. ICC
Halprin, E. G. OCC
Hammon, John W. ChCC
Hansen, L. H. ChCC
Hanser, Charles F. ICC
Harler, A. J. ICC
Harmon, Roy C. OCC
Harvey, M. ICC
Hawk, Paul M. ICC
Hayes, Jerry ChCC
Heidenreich, Irvin A. ICC
Heifitz, Samuel C. OCC
Hein, James M. OCC
Hertz, C. LCP
Hewett, Arthur T. OCC
Hilbronner, Stanley OCC
Hiles, C. ChCC
Hill, H. Lloyd OCC
Hill, Joel OCC
Hill, Walter ICC
Hindes, Erwin B. ICC
Hindes, E. M. ICC
Hines, F. ChCC
Hoag, Gerald ICC
Hofreiter, B. G. ICC
Hogan, G. D. ICC-OCC
Holdeman, R. E. ICC
Hollins, Benjamin OCC
Holmes, Sidney OCC
Hommel, Edward R. ICC
Hommel, W. H., Jr. ICC
Hommel, William J. ICC
Hopkins, John S. ICC
Horowitz, Jack OCC
Hostetter, Paul OCC
Houx, Leonard OCC
Howard, C. T. ICC
Hugar, D. ChCC
Hultgren, C. A. ICC
Hunt, Don W. ICC
Hurd, Edward B. ICC
Hurtienne, Eugene V. ICC
ICC & FS, Class of 1959 ICC
Ignatoff, W. B. ICC
Inbody, H. ICC
Isenberg, Gerald OCC
Jackson, Wm. M. ICC
Jacob, David E. ICC
Jacobson, Bernard H. ICC
Jacobson, O. A. ICC-ChCC
Jacoby, Robert L. CaCC
James, Delores OCC
James, Helen OCC
Johnson, C. ChCC
Jorgensen, Keith W. ICC
Junod, D. A. ICC
Kaczmarek, C. S. OCC
Kaczur, Louis OCC
Kaiser, E. J. ICC
Kaldahl, Henry N. ICC
Kane, John OCC
Kannelly, Richard OCC
Kaplan, Earl OCC
Kapnick, Louis ChCC
Kartel, Joseph L., Jr. ICC
Katz, Kenneth OCC
Katz, Murray OCC
Katzman, Harry OCC
Kaufman, I. ChCC
Keen, John OCC
Keenan, C. E. ICC
Kelly, Burgess F. ICC
Kelly, J. O. ICC
Kelly, William H. OCC
Ketai, Donald OCC
Ketola, F. H. ICC
Killeen, William P. ICC
King, Leroy CaCC
King, W. S. ICC
Kingland, Ray ICC

Kirkwood, Ralph C. ICC
Kirsner, Milton OCC
Klicker, L. F. OCC
Kligman, Leo I. CaCC
Knight, Irvin OCC
Knoch, Stanley A. ICC
Knowles, Carolyn OCC
Knowles, Hergert OCC
Knowles, Olive OCC
Kockinis, Angelo CaCC
Koffman, Harold ICC
Kohn, Jack M. ICC
Korn, H. C. ICC
Kortsch, Kevin P. ICC
Kouffman, S. H. OCC
Kozie, Lee ChCC-ICC
Kraft, Mildred OCC
Kramer, M. ICC
Krantz, Milton K. ICC
Krause, L. E. ICC
Krausz, Charles ICC-OCC
Krausz, Sidney OCC
Krayer, John D. ICC
Krimm, George OCC
Krueger, Ann L. ICC
Krueger, Howard W. ICC
Kubinski, Robert OCC
Laine, Wilfred OCC
Lamm, Stephen OCC
Lane, K. E. ICC
Larson, C. R. OCC
Larson, T. J. ICC
Latzanich, George OCC
Latzanich, Michael OCC
Lawson, Harry OCC
Lazar, Max OCC
Leavitt, Robert E. ICC
LeDuc, Donald K. ICC
Lee, Raymond E. ICC
Lenk, Matilda OCC
Leone, Patrick OCC
Levey, William ICC
Levin, Harvey ICC
Levin, Mark OCC
Levine, Jerome OCC
Levine, Morton OCC
Levy, Theodore OCC
Lewis, Milton ChCC
Libanoff, Arthur ICC
Lindenberg, L. M. ICC
Lindy, Harry OCC
Liss, Dr. & Mrs. Leo N. CaCC
(In memory of Mr. Bernard Jacques)
Little, William OCC
Livers, Lorene OCC
Lobb, A. ChCC
Locke, Raymond OCC
Loome, T. J. ChCC
Lunter, M. E. OCC
Lynch, E. M. ChCC
Lynch, M. ChCC
Lyon, Paul OCC
McAninch, H. A. OCC
McAvoy, G. L. ICC
McCain, Lyle R. ICC
McCarthy, Daniel OCC
McCay, Thomas F. ICC
McCormick, Richard OCC
McCullough, W. Jean OCC
McKay, Frank J. ICC
McOzker, John OCC
M. J. Lewi College of Podiatry, Class of 1953 LCP
Macey, W. P. ChCC
MacVeigh, James C. OCC
Machade, W. E. OCC
Madaras, Michael OCC
Mahaffy, Paul J. ICC
Mahler, I. ICC
Malkin, Walter OCC
Marconi, Frank OCC
Margolin, Phillip OCC
Marr, M. D. ICC
Marshall, R. F. ICC
Martin, E. C. ICC
Martin, F. F. ICC
Martin, W. G. ICC
Martindale, Allen R. ICC
Marzano, Daniel OCC
Mason, C. C. ICC
Mason, T. ICC
Mattingly, E. ChCC
Mattison, John L. ICC
Mauney, William L. ICC
Maury, Robert OCC
Max, Samuel OCC
Mayland, E. R. ICC
Meade, J. C. ICC
Meadors, William OCC
Meaney, David A. OCC
Medwid, S. ChCC
Meece, Ralph OCC
Meier, George LCP
Meinecke, R. ChCC
Meints, C. L. ICC
Mellert, W. G. OCC
Merrick, L. A. LCP
Merrigan, Margaret ICC
Mertz, William H. OCC
Meyer, C. J. ICC
Meyer, Curry L. ICC
Meyer, Harry F., Jr. OCC
Meyer, Thomas OCC
Meyers, Leon OCC
Michael, Budd H. ICC
Michael, Charles OCC
Miller, D. M. ICC
Miller, Frank CaCC
Miller Shoe Co. ICC-ChCC-CaCC-LCP-OCC
Missouri Association of Chiropodists, St. Louis ChCC
Misuraca, Charles A. ICC
Mohr, Raymond L. ICC
Monaco, A. CaCC
Montague, John P. OCC
Moon, C. L. ICC-GF
Moore, James W. ICC
Moran, S. P. ICC
Morden, Thomas R. ICC
Moriarty, T. ChCC
Morris, Jonas C. OCC
Mosena, C. J. ICC
Mostone, C. A. OCC
Mowbray, D. T. ICC
Muir, Douglas OCC
Munsey, William OCC
Murray, Paul OCC
Myer, Eugene OCC
Myers, Charles F. OCC
Myers, D. Wayne OCC
Myers, Malcolm OCC
Myers, Warren H. OCC
Nankee, William OCC
Nelson, Dr. & Mrs. P. B. CaCC
(In memory of Mrs. Greeta Cole)
Neuhaus, Edward OCC
Nichols, Dr. & Mrs. Robert CaCC
(In memory of Mrs. Sylvia Weinberg)
Nicklas, Robert OCC
Nielsen, Kenneth C. ICC
Nirschl, Harold M. ICC
Niswonger, B. R. OCC
Noonan, Raymond J. ICC
Norway, Samuel OCC
Nuddleman, M. C. CaCC
Nutt, W. L., Jr. ICC
Nyman, S. P. ICC
Oberling, Roy OCC
O'Dwyer, A. ChCC
O'Grady, Harold OCC
O'Leary, Pat R. ICC
Oliver, A. G. CaCC
Oppenheimer, Leo D., Jr. ICC
Order, Lloyd OCC
Ormond, Dr. & Mrs. C. S. CaCC
(In memory of Caryl L. Smith)
Ornstein, Seymour ICC
Orr, Harold OCC
Orr, Ralph OCC
Ossenberg, Charles OCC
Owens, Ralph ChCC
Paes, Joseph C. OCC
Palestrant, N. A. OCC
Parham, C. ChCC
Parven, Howard OCC
Patterson, Percy W. ICC
Patton, George D. ICC
Patton, George O. ICC
Paul, Bernard S. ICC
Pearce, Richard D. ICC
Pellegrini, Edward R. ICC
Penny, A. O. OCC
Perendy, William OCC
Perkins, R. D. ICC
Perrone, Michael OCC
Perry, Groover OCC
Persky, H. B. OCC
Peterson, Walter OCC
Phi Alpha Pi Fraternity ChCC
Pickett, N. J. ICC
Pickarsky, Paul OCC
Pigula, Lawrence ICC
Pock, L. ChCC
Pollack, Herman OCC
Polley, William OCC
Polokoff, Morton OCC
Polom, Anthony T. ICC
Pont, Nelson OCC
Potter, William W. ICC
Prives, Israel OCC
Pusateri, Samuel OCC
Raidbard, A. ChCC
Rapisarda, Joseph OCC

Rappaport, Mark	OCC
Rebacz, Stanley J., Jr.	ICC
Redwood Division, C.A.C.	CaCC
Reed, Stewart E.	ICC
Reinheimer, Claude	ICC
Reinking, A. C.	ICC
Reisgraf, Lola T.	ICC
Ressler, D. D.	OCC
Reyer, J. F.	OCC
Rhodes, Orphelia S.	ICC
Rich, P. P.	OCC
Richert, Arthur	ICC
Rickoff, Nat	OCC
Ridinger, John	OCC
Riester, William R.	OCC
Riley, John H.	ICC
Ripple Sole Corporation	ICC
Ristvey, J.	ChCC
Ritz, Carl	ChCC
Roberts, E. H.	LCP
Robin, Gerald M.	ICC
Roddy, Dr. & Mrs. Marion E. (In memory of Bernard Jacques)	CaCC
Rogers, Flake	ChCC
Rogers, Virgil	OCC
Rohacz, Eugene	ICC
Romani, Bernard	OCC
Root, Merton L.	CaCC
Rosen, Max	OCC
Rosen, Stanley	OCC
Rosenblum, H.	CaCC
Rosenfeld, Emanuel	OCC
Rosenfeld, Hy	ChCC
Rosenfeld, Saul	ChCC
Rosenthal, D. E.	ICC
Rosenthal, S.	OCC
Roth, Jerome	OCC
Roth, Milton	OCC
Rubin, A.	ICC
Ruekert, Joseph G.	ICC
Ruff, A.	ChCC
Russell, D. A.	OCC
Russo, Patrick	ChCC
Rutherford, R. L. (In memory of Oran Vetterli)	CaCC
Saari, Mary C.	OCC
Sacks, Ben I.	ICC
Sandel, Kenneth	OCC
Sanders, Jack	CaCC
Sansone, Ralph E.	ICC
Saperston Laboratories	ICC-ChCC
Sartor, Alice J.	ICC
Sauder, Harold J.	ICC
Sawyer, G. Wesley	OCC
Schaeublin, Lowell	OCC
Schaffer, John C.	ICC
Schatzberg, S.	ICC
Scheimer, Herbert	OCC
Scheimer, O. M.	OCC
Schere, Robert	ICC
Scherer, Charles E.	ChCC
Scherer, Robert R.	ICC
Schevley, R. R.	ICC
Schilling, Edna	OCC
Schindler, Samuel	OCC
Schindler, Meyer K.	OCC
Schivley, J. Kenneth	ICC
Schivley, R. R.	ICC
Schrier, H. R.	OCC
Schroedel, Esther	OCC
Schroer, George	OCC
Schurig, Gerald	OCC
Schwartz, Morris	OCC
Schwein, David	OCC
Scioli, Eugene	ChCC
Seeber, H.	ICC
Seeber, H. W.	ICC
Seiler, Joseph E.	ICC
Selby, Morris	OCC
Seller, Joseph E.	ICC
Semonton, E. E.	ICC
Settler, Joseph	ICC
Seulean, Myron	ICC
Shaen, Norman	OCC
Shafer, Robert	OCC
Shagrin, Seymour	OCC
Shanley, J. D.	ICC
Shapiro, Marvin	OCC
Sharp, Bernard	ICC
Shaw, R. E.	ICC
Shelton, L. R.	OCC
Shelton, Tom	OCC
Shepler, M. A.	OCC
Sherman, Howell	OCC
Sherman, Norman	OCC
Shivley, J. R.	ICC
Shogren, C. V.	CaCC
Shore, George	OCC
Shuchat, Joseph	OCC
Siebert, P.	ChCC
Silk, Samuel M.	ICC
Silver, Alan	OCC
Simonton, E. E.	ICC
Singer, Harold	OCC
Skwor, Donald R.	ICC
Slowick, Albert W.	ICC
Smik, Stephen	OCC
Smith, Ben	OCC
Smith, G. L.	ICC
Smith, George J.	ChCC
Smith, Jesse	ICC
Snyder, K. G.	ICC
Sollod, Alvin	OCC
Solomon, Gilbert	ICC
Solomon, Irvin	OCC
Solomon, Seymour	OCC
Sosinski, Carl	OCC
Sottek, Edward M.	ICC
Speisel, Frank	OCC
Spinelli, John	OCC
Spring, Howard	OCC
Starr, Joseph	LCP
Stein, Charles	OCC
Stern, Benjamin C.	ICC
Stewart, R. R.	OCC
Stiles, Cortland	OCC
Stivers, J. T.	ChCC
Stivers, P. R.	ChCC
Stivers, R.	ChCC
Stivers, R. E.	ChCC
Stoler, William	OCC
Stone, J. J.	OCC
Stricker, J. Edward	ICC
Struble, Allen C., Jr.	OCC
Stucky, L. R.	ICC
Stucky, LeRoy	ICC
Suppan, R. J.	ICC
Suppan, Raymond	OCC
Swearingen, H. G.	ICC
Sweeney, Joseph	OCC
Sweeney, Joseph M.	OCC
Szwalek, Leo	OCC
Tack, Henry C.	ICC
Taggart, W. F.	OCC
Taicher, L. L.	ICC
Tanner, R. E.	ICC
Tapper, David	OCC
Tarara, E. L.	ICC
Taughinbaugh, C. A C.	CaCC
Taylor, Grandell	OCC
Thomas, William J.	ICC
Thompson, E. E.	OCC
Thompson, E. S.	ICC
Thompson, L. B.	ICC
Thornton, Walter M., Jr.	ICC
Titus, Jesse	OCC
Tobin, Don	OCC
Topal, Mrs. Matilda	ChCC
Toth, Frank	OCC
Trent, Robert S.	ICC
Trewartha, William	ICC
Tri County Division, C.A.C.	CaCC
Trimborn, Oliver J.	ICC
Trowich, R. G.	ICC
Tucker, Basil M.	ICC
Turchin, Charles	ICC
Turner, Nicholas R.	ICC
Turner, Richard A.	ICC
Tyburski, Sy A.	OCC
Uchimura, M.	ICC
Ueland, Ernest	OCC
Ulanet, M.	OCC
Vallon, Richard	OCC
Vansgard, G. E.	ICC
Varzos, Peter N.	ICC
Vegnone, Nicholas	OCC
Vieg, Roy M.	ICC
Vollman, Donald	OCC
VonDraska, D. (In memory of Dr. David Roberts)	CaCC
VonDraska, D. (and friends) (In memory of Mrs. Pearl VonDraska)	CaCC
Wagner, C.	ChCC
Wagner, Lesley W.	ICC
Wagner, Thomas	OCC
Walker, Robert E.	ICC
Walters, Helen F.	ICC
Ward, Ray G.	ICC
Ward, William L.	ICC
Watson, William	OCC
Watts, A. Roscoe (In memory of Frank Robinson)	CaCC
Watts, C., Jr.	ChCC
Weaver, Edwin	OCC
Webb, Wanita	OCC
Wechsler, Bernard	OCC
Weibel, A. S.	ICC
Weibel, Earl	ICC

Weinberg, Joseph	OCC	Wheeler, Harold E.	ICC	Wright, Robert L.	ICC
Weingarten, Harvey	OCC	Whitten, L. Wayne	ICC	Wunderlich, C. H.	ChCC
Weinstein, Bernard	OCC	Wickham, Arthur	OCC	Wysocki, Robert	OCC
Weinstein, F.	ChCC	Wicks, Vaughn E.	ICC	Yacks, Joseph	ICC
Weires, Michael C.	ICC	Wiesman, Albert	ICC	Yaeger, G. J.	OCC
Weisberger, Eugene	OCC	Williams, Earl	OCC	Yale, Irving	ICC
Weiseman, H. G.	ICC	Wilson, John E.	ICC	Yard, Tom M.	ICC
Weiss, Dennis	OCC	Wilson, Ralph	OCC	Yee, Helena	OCC
Weiss, George	ICC	Wish, Andrew	OCC	Yonngelson, Garrison	ICC
Weiss, Stephen G.	ICC	Witherow, Robert	ICC	Young, D. E.	ICC
Weissfeld, Arthur	OCC	Witherow, S. L.	ICC	Zak, Robert	OCC
Wells, Von S.	ICC	Wojtak, V.	ChCC	Zarras, T.	OCC
Wendt, Herbert	OCC	Wolff, Sam	ICC	Zeolla, Anthony	OCC
Wentzlaff, W. M.	OCC	Woodford, Thomas	OCC	Zichichi, Nicholas	ICC
Western Chiropody Congress	CaCC	Woofter, Glen	ChCC	Ziegler, John	OCC
		Worrell, H.	LCP	Zimmer, Charles	OCC

AND NOW FOR 1960

The results of the efforts in 1959 at first glance may seem small but for a first year effort, it represents a high acceptance of this concept by the members. In its first year the medical education fund sponsored by the American Medical Association collected approximately $46,000. As we as a profession demonstrate our willingness to assume our share of our obligation we can anticipate enlisting support from extra professional organizations, industry and foundations.

This excellent beginning must be made to snowball by each individual contributing his share. Don't wait for a chairman to call upon you. Have your receipt ready to show him by filling out the pledge on page 14 and sending it in today with your check.

WASHINGTON REPORT

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Food and Drug Administration

Addition of unsaturated fats and oils to the otherwise unchanged ordinary diet will not reduce blood cholesterol and prevent heart attacks and strokes, the Food and Drug Administration said recently. Representations to the public that salad oils, shortenings, oleomargarine, and similar products have value for these purposes are false and misleading and will cause such products to be misbranded, FDA declared in a statement of law-enforcement policy published in a recent Federal Register.

George P. Larrick, Commissioner of Food and Drugs, said there is widespread interest in the possible relationship between blood cholesterol levels and heart and artery diseases. As a result, he explained, reference to the term "cholesterol" in the labeling of common foods now being offered to the public may have the effect of a claim of special value for preventing or treating these diseases.

Commissioner Larrick added:

"Scientific investigations of fatty substances as a possible factor in lowering blood cholesterol and preventing heart disease should be continued, and this policy statement does not interfere in any way with legitimate research and clinical evaluation of unsaturated fats in the diet. It is our responsibility, however, to point out that the public has been misled into relying prematurely on data which are still experimental, incomplete, and contradictory, and to head off false and misleading promotions based on such data."

Cholesterol, FDA explained, is a substance that is manufactured in the body and has an important function in many of the body tissues. It is also present in animal fats and oils such as butter, lard, bacon, and meat fat. The blood level of cholesterol is controlled largely by synthesis in the body and is affected very little by the amount present in our foods.

FDA further pointed out the view of nutrition scientists that it is impracticable for a person to add enough unsaturated fats to an otherwise unchanged diet to bring about any significant change in blood cholesterol. Increased weight, they add, is the only result that is likely to be achieved by increasing the intake of fats.

The FDA policy statement, based on an extensive survey of leading medical authorities, follows:

> 3.41 Status of articles offered to the general public for the control or reduction of blood cholesterol levels and for the prevention and treatment of heart and artery disease under the Federal Food, Drug, and Cosmetic Act.
>
> (a) There is much public interest and speculation about the effect of various fatty foods on blood cholesterol and the relationship between blood cholesterol levels and diseases of the heart and arteries. The general public has come to associate the term "cholesterol" with these diseases. A number of common food fats and oils and some other forms of fatty substances are being offered to the general public as being of value in the control or reduction of blood cholestrol levels and for the prevention or treatment of diseases of the heart or arteries.
>
> (b) The role of cholesterol in heart and artery diseases has not been established. A causal relationship between blood cholesterol levels and these diseases has not been proved. The advisability of making extensive changes in the nature of the dietary fat intake of the people of this country has not been demonstrated.
>
> (c) It is therefore the opinion of the Food and Drug Administration that any fats and oils or other fatty substances offered to the general public that they will prevent, mitigate, or cure diseases of the heart or arteries is false or misleading, and constitutes misbranding within the meaning of the Federal Food, Drug, and Cosmetic Act.

BOOK REVIEWS

"GRAY'S ANATOMY"

Henry Gray, F.R.S., Revised and edited by Charles Mayo Goss, M.D., Managing Editor of "Anatomical Record"; Professor and Head of the Department of Anatomy, Louisiana State University, New Orleans. American Centennial (27th) Edition, $17.50, 1,458 pgs., 7″ x 10″, 1,174 illustrations, most in color, Lea & Febiger, Washington Square, Philadelphia 6, Pa., August 1959.

The completely revised 27th edition of Gray's Famous Anatomy is a fully illustrated classic of anatomy text. It contains 1,458 pages and 1,174 illustrations, most in color. In this new edition, clarity of statement has been improved by thorough revision without sacrificing information that is of value. Of particular interest in this new edition are the following revisions: The Cardiovascular System which has been divided into three parts—Heart, Arteries and Veins—each with its own section on embryology. The chapter on Heart has been completely rewritten, with new illustrations added. The arteries of the upper abdomen are described more fully than before. The section on the Central Nervous System has been rewritten, simplified and illustrated more fully. The Endocrine System was rewritten. Embryology and Histology are presented more uniformly. The new Paris nomenclature is used virtually throughout the text. All familiar aspects of Gray's are retained.

The 16 chapters, references, Index to Bibliographies and Subject Index are uniformly presented and provide a wide coverage in the field of Anatomy. Included in the above chapters are: Embryology, Surface and Topographical Anatomy, Osteology, Joints and Ligaments, Muscles and Fasciae, The Cardiovascular System, The Lymphatic System, The Nervous System, The Central Nervous System, The Peripheral Nervous System, The Organs of the Senses, The Integument (Skin), The Respiratory System, The Digestive System, The Urogenital System and The Ductless Glands.

There is a minimum of redundant material so that the salient features stand out as they should and lighten the tasks of the reader in understanding the text. While the basic anatomy of the human structure does not change, much has been learned of great clinical significance in recent years. Because of advances in technic, many details and concepts previously overlooked are now of great importance. Therefore you will find that this book contains much new information which applies to the problems of everyday podiatry practice. For the student this volume has served as a textbook for many years since it approaches the subject of anatomy in the same way as approached in the curriculum. No one genuinely interested in detailed human anatomy should be without a copy of this fine book.

Jack Ranzer, Pod.D.

THE FOOT AND ANKLE

Philip Lewin, M.D., F.A.C.S., Professor Emeritus of Bone and Joint Surgery and Formerly Head of Department, Northwestern University Medical School; Professor of Orthopedic Surgery, Post-graduate Medical School, Cook County Hospital. Pp. 612, with 339 Illustrations. Fourth Edition, 1959, Lea and Febiger, Philadelphia, Pa., Price, $14.00.

This new fourth edition has been written to conform to the present-day accepted concepts of etiology, diagnosis, and treatment of pathologies involving the foot and ankle.

The presentation form is similar to the earlier editions with many new subjects and illustrations added. The book is most attractive, the paper excellent, and the large print agreeable to the eye.

Dr. Lewin deals with many problems in an excellent manner. Trauma, rehabilitation, and the psychosomatic disorders with relation to trauma are included in the general outline, together with the paralytic disabilities, deformities, congenital defects, developmental disorders, and infectious lesions.

The chapters of this text contain such information as the anatomy, physiology, and biomechanics in relation to physical diagnosis and examination. The basic principles of conservative treatment for congenital defects, static deformities and digital deformities are presented along with the newer surgical approaches to these pathologies. Heel pain, bone structural deformities, soft tissue pathology, infection, arthritis, systemic and neurologic involvements of the foot and ankle are treated in the same fine manner.

Excellent reference is made to the military, athletic, and industrial aspects of the foot and ankle; together with the modern concepts in therapy for poliomyelitis and cerebral palsy which pertain to the pedal extremities.

A fine reference is made to Podiatry-Chiropody, with great stress placed on the close cooperation needed between Medicine and Podiatry. The scope of our profession is well defined and mention is made that the podiatry profession has developed many minor surgical procedures of its own for the permanent removal of corns, warts, and ingrown toenails.

This encyclopedic text is the result of careful research and planning and a must for any doctor dealing with the foot and ankle; and will serve as a guide to their treatment. *Arthur E. Helfand, D.S.C.*

TAX CLINIC

HENRY KENT, C.P.A.
New York, N. Y.

Mr. Kent will conduct a regular column on tax problems for the podiatrist-chiropodist. Your questions may provide the basis for future columns.

JOINT OR SEPARATE TAX RETURNS

ONE of the best known elections available to individual taxpayers is the option that married taxpayers have in filing either joint or separate tax returns. In order to be eligible to file a joint return, a husband and wife must be married at the end of the taxable year, both spouses must have the same taxable year (i.e., the husband cannot report on a fiscal year basis and his wife on a calendar year. A fiscal year for income tax purposes is a twelve months period ending on the last day of a month other than December—such as March 31st. A calendar year always ends on Dec. 31st) and neither spouse must have been a non-resident alien at any time during the taxable year. A couple need be married only at the end of the taxable year and not the entire year in order to qualify for a joint return. Here is perhaps one of the few instances where a bachelor marrying on or about December 31st can have his cake and eat it too—at least taxwise. Incidentally, it is not necessary, at least not for income tax purposes, that a husband and wife have lived together at any time during the taxable year. However, the Code specifically provides that "an individual who is legally separated under a decree of divorce or of separate maintenance shall not be considered married."

The effect of a joint return is simply that half of the income is attributed to the husband and half to the wife, and the tax is calculated on one-half of the income multiplied by two. Because the income tax rates are graduated, the filing of a joint return almost always results in a lower tax. For example, after the appropriate deductions, including the personal exemption deduction, your own taxable income for 1959 is $8,000.00. By filing a joint return, your income tax would be $1,680.00. If you had computed your tax on a separate return, your tax liability would be $1,960.00. By filing a joint return, you have saved $310.00 in taxes. If your wife has income of her own, you must also include her income in a joint return, but if your wife's earnings are less than yours, the filing of a joint return will, in most cases, save you taxes. Thus, for example, if your combined net taxable income (after all deductions and exemptions) amounts to $12,000.00 in 1959—consisting of $10,000.00 of your income and $2,000.00 of your wife's—your tax bill by filing a joint return would be $2,720.00. By filing separate returns, your income tax based on $10,000.00 would amount to $2,640.00 and your wife's tax on $2,000.00 would amount to $400.00 or a combined tax of $3,040.00. Of course, the higher the income, the greater the possible tax savings by filing joint returns.

However, a joint return is not always advantageous. Under the pressure of an impending tax return due date, the married taxpayer may fall into a tax trap by relying on the general rule that a joint return always provides tax benefits. For by filing an unnecessary joint return he may innocently create for himself a tax burden because the election to file a joint return in any taxable year is binding and cannot be revoked. The election is available annually but once you elect to file a

joint return, you cannot revoke this election for that particular taxable year.

Here are some joint return disadvantages which may result in a higher tax. Where both spouses have capital losses in excess of capital gains, the deduction on a joint return is limited to $1,000.00 against ordinary income, whereas on separate returns, *each* spouse would be allowed to deduct $1,000.00. Another example of a possible disadvantage would be where both spouses have some income, separate returns might be indicated if one of the spouses has extraordinary medical expenses. Medical expenses are deductible only to the extent that they exceed 3% of the taxpayer's adjusted gross income (except for taxpayers 65 years or older). On a joint return the medical expenses must, therefore, exceed 3% of the combined income of husband and wife. Therefore, by filing separate returns, the medical expense deduction will be larger since the 3% disallowance is based on a smaller gross income. A word of caution if a married couple files separate returns and one of the spouses itemizes the deductions such as medical expenses, contributions, etc., the other must also itemize and cannot elect to take the so-called standard deduction on his return.

If there is a net operating loss carryback, the filing of a joint return might be disadvantageous. Since net operating loss carryovers are a highly technical subject and only very rarely applicable to professional taxpayers, only a mention is made here of that possibility in order to draw taxpayers' attention to its existence.

Finally, where the taxpayer's income is in a low tax bracket or where both husband and wife earn approximately the same amount of income, there may be no or a very insignificant tax saving in filing a joint return. By filing a joint return, the liability for any future assessment is joint—each spouse is liable for the entire amount of the tax, not merely the tax attributable to his specific income. In such cases, where the tax savings of a joint return are insignificant, the filing of separate returns would only create individual liabilities against any possible future tax deficiencies assessed against a spouse. While the filing of a joint return creates a binding and irrevocable election once the due date for filing a tax return has passed, the election to change from separate returns to joint return can be made any time up to three years after the due date of the return. Thus, for 1959 tax returns due on April 15, 1960, the change can be made up to April 15, 1963. But, by filing an amended return, the taxpayer will subject himself to a possible tax audit. The mechanics of filing a joint return are simple—the names of both husband and wife should be entered on the form, the income and deductions of both included, and both spouses must sign the return.

The tax benefits of a joint return are also available to an unmarried widow or widower for the first two taxable years following the year in which the husband or wife died. To qualify, the surviving spouse must not remarry and must maintain at his home a household which must include a son or daughter for whom a dependency deduction is allowable. Of course, a joint return is allowable in the year the spouse has died.

To conclude, while the filing of a joint return is in most cases advantageous, a careful examination of all the facts may reveal some disadvantages and additional tax expense in some other instances. In the next issue, this column will discuss education expenses and some other important tax saving opportunities.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Old Favorite Pharmaceuticals Still Used

A search of podiatry-chiropody literature of the years 1909-1914 reveals that practitioners in those days used many of the following pharmaceutical preparations that are still in use today. This information has been collected and submitted by the American Board of Chiropodical Dermatologists for the information of our members.

General Dermatologic Pharmaceuticals

Balsam of Peru, Balsam of Tolu, Tincture Benzoin Compound, Tincture Benzoin, Resorcin, Resorcinal, Menthol, Camphor, Gum Tragacanth, Ether, Tincture Belladonna, Unna's Boot, Lassar's Paste, Ferric Subsulphate, Alcohol, Iodine, Glycerin, Phenol, Mercuric Chloride, Hydrogen Peroxide, Salicylic Acid, Citric Acid, Normal Saline Solution, Adrenaline Chloride, Aqua Regia, Potassium Nitrate, Potassium Hydroxide, Carbonic Acid Snow, Eucalyptus, Formaldehyde, Guaiacol, Magnesii Sulphas, Paraffin, Methyl Salicylate, Oleum Morrhua, Oleum Ricini, Pix Liquida, Oleum Theobromatis, Nitric Acid and Phenol, Aluminum Subacetate, Lead Subacetate, Acetylsalicylic Acid, Potassium Permanganate, Sapo.

Favorites for Hyperidrosis were:

Formaldehyde or Tannic Acid and Alcohol.

Favorites for Bromidrosis were:

Salicylic Acid, Alum and Lycopodium, Silver Nitrate, Iodoform, Chloroform, Collodion, Acetic Acid, Mono-Di-Tri-Chloracetic Acid, Soda Bicarbonate, Talcum, Sodium Borate, Picric Acid, Zinc Oxide, Amylum, Thymol, Boric Acid, Ichthyol, Adeps, Adeps Lanae Hydr., Tannic Acid, Aloes, Alum, Ethyl Chloride, Bismuth Subnitrate, Bismuth Subgallate, Adeps Lanae Hydrosus.

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PODIATRY-CHIROPODY ABSTRACTS

JEROME SHAPIRO, Pod.D.
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Washington, D. C.

Editors of Local, State and Regional Publications are requested to provide copies to Dr. Shapiro who is editing this section of the Journal.

SUBLUXATIONS OF THE METATARSOPHALANGEAL JOINTS

Milton Henefeld, Pod.D., and Milton H. Walkes, Pod.D., New York State Journal of Podiatry, Vol. XX, No. 9, Sept. 1959.

The chief causes of subluxations of the metatarsophalangeal joints are: 1) rheumatoid arthritis, 2) constant trauma from footgear, 3) muscular imbalance, 4) tumors of bones or joints.

Partial subluxations are usually accompanied by hammer toe formation with a bursitis of the dorsal surface of the toe and tyloma beneath the involved metatarsal heads. Complete subluxations present symptoms of a much greater severity. A deep-seated corn usually develops under the involved metatarsal head with a chronic bursitis and inflamed corn over the accompanying toe.

Routine non-surgical treatment employed consists of traction, manipulation, injection therapy and weight dispersion pads. The authors feel that all these forms of conservative therapy fall short, for they do not overcome the pathological changes that have occurred, mainly contraction of joint capsule and ligament, muscle shortening, damaged cartilage and abnormal positioning of the opposing bony surfaces. It is felt that the only definitive approach is a surgical one, with more attention being paid to the opposing phalanx. The surgical procedure consists of the removal of the base of the proximal phalanx of the involved joint. This operation is designed not to correct the deformity, but rather to overcome the pathology by permitting the parts to function without interference, thus relieving the pain, limitation of motion, and the lesions accompanying this condition.

By resecting the base of the proximal phalanx the subluxation is overcome, the contraction of the peri-articular soft tissues no longer exists, and because of the toe shortening, the tendon is relieved of tension.

A PRELIMINARY REPORT ON HYPNOSIS IN PSYCHOSOMATIC PODIATRY

Jack T. Sanders, D.S.C., The American Academy of Psychosomatic Podiatry Newsletter, Vol. 1, No. 6, Sept. 1959.

Enough interest in hypnosis and psychosomatic medicine has been generated to form The American Academy of Psychosomatic Podiatry. Members are attempting to create adequate training programs, with one such course scheduled in the Fall of 1959 at the California College of Chiropody.

Podiatrists are presently engaged in research in hypnosis and psychosomatic podiatry and their findings will soon be available for publication. At this point most techniques used by the podiatrist are modifications of those used by medicine and dentistry.

Hypnosis is the technique used exclusively in the podiatric management of psychosomatic problems. The podiatrist, of course, is not concerned with the patient's psychic disturbances, but local symptoms can be eliminated through the use of physical modalities in conjunction with suggestion.

The author reports that hypnosis can be used safely on a neurotic patient, depending on technique and purpose. It is particularly successful when used for anesthesia, and has been found effective in shortening the period of surgical repair. Hypnosis has also proven effective in the treatment of heel spurs and symptomatic relief from arthritis. In children non-pathological in-toeing and out-toeing have been corrected without the use of braces or exercise.

PLANTAR INCISIONS

Charles W. Corbett, D.S.C., Footprints, Vol. 14, No. 3, Nov. 1959.

The author attempts to allay the fear acquired through the literature as well as in classroom instruction regarding plantar incisions. Cases of traumatic plantar lacerations with uneventful recovery and a symptomatic minimal scarring are cited along with plantar excisions of verrucae, keratoses, epidermoid cysts and foreign bodies. The results of minimal scarring encouraged the author to excise intractable keratoses at the plantar areas of metatarsal heads using this plantar approach to the metatarsal head condyle for a DuVries technique.

A case history is noted of such a double procedure. In conclusion it is felt that plantar surgery is possible and practical in many instances where orthopedic means alone do not afford relief and where palliative measures fail.

VASODILATION TEST AND ITS USE IN PODIATRY

Earl R. Horowitz, D.S.C., FootPrints, Vol. 14, No. 3, Nov. 1959.

Herein is described a test to be used to: 1) evaluate results of a sympathectomy, 2) differentiate functional from organic vascular disease, 3) determine adequacy of collateral circulation, 4) measure venous spasm.

The test is based upon the physiological phenomenon that when heat is applied somewhere else on the body, vasodilation of the extremities occurs due to stimulation of the temperature–regulatory center of the brain and initiation of afferent impulses in the heated skin.

A test is described whereby vasoconstriction is overcome by local anesthetic blocks, vasodilator drugs or reflex heat. The resulting blood flow equals the undamaged circulation plus the collateral circulation. The rate of this blood flow is noted clinically by measurements of skin temperature at the digital areas. The environmental temperature of the examining room must be kept at a constant temperature (20 degrees centigrade). This test can be considered extremely important where one has to determine whether a patient shall be continued on conservative therapy.

THE MANAGEMENT OF POSTERIOR HEEL PAIN

L. C. Gibbard, M.Ch.S., British Chiropody Journal, Vol. 24, No. 9, Sept. 1959.

The most common cause of posterior heel pain with its concurrent pain at the medial and lateral borders of the os calcis is the irritation of the shoe counter. Since this area of the heel is lacking in adipose tissue it is easily irritated by the stiff counter of a new shoe. This constant iritation produces a periosteal reaction with a laying down of new bone, with the resultant hypertrophy further adding to the shoe pressure. The author suggests a softening or removal of the shoe counter or sponge padding in the counter area.

The heel counter is also blamed for the fibrosis and bursitis which occurs at this site. The tough fibrous nodules usually follow chilblains at this site, whereas the bursitis is usually caused by trauma or heavy exercise involving increased use of the achilles tendon. Brief mention is made of tuberculosis, osteomyelitis, Sever's Disease and gout as possible causes of posterior heel pain.

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

ARTHRITIS; RHEUMATIC DISEASES

Juvenile Rheumatoid Arthritis, A. M. Murtland and J. F. Whitehill, Jr. Guthrie Clin. Bull. 28: 58-68, 1958.

The incidence of rheumatoid arthritis in children is much higher than previously suspected. Onset is reported as early as 15 months of age, with the peak incidence coming between the second and third year. Differentiation between rheumatoid arthritis and rheumatic fever in the child is difficult. Cardiac involvement occurs in most of the severe cases, causing a suspicion of rheumatic fever. The electrocardiogram distinguishes between the two diseases. The normal P-R segment is the distinguishing point.

The clinical picture of juvenile rheumatoid arthritis ranges from insidious monoarticular involvement to sudden onset with severe generalized systematic disease, together with a high spiking fever, fatigue, anorexia, and a discrete maculopapular rash. This rash has been observed in 75 to 80 per cent of cases during the febrile periods, is widespread over the body, and is considered a diagnostic sign. Arthralgia may be a transient early symptom. Usually a single joint is involved in the beginning.

Rheumatoid arthritis passes through four stages: (1) synovitis, (2) hypertrophy of the synovia with pannus formation, (3) fibrous ankylosis, (4) bony ankylosis. Varying stages of involvement occur in different joints at the same time. The joints first involved are the knee, hand, elbow, and ankle, usually in that order. The joint capsule is inflamed, edema and congestion cause thickening of the synovia, leading to synovial proliferation (pannus) and invasion of the interior of the joint. Interference with nutrition of the articular capsule causes slow destruction. Destruction also follows invasion of the cartilage of bone and joint, causing osteoporosis of the bone. Synovitis subsides after pannus formation and cartilage damage, and a tough fibrous tissue replaces the inflamed tissues, which in turn inhibits joint movement. The fibrous tissue calcifies, changes to osseous tissue, and causes bony ankylosis.

Treatment is planned for relief of pain, prevention of deformities if possible, and restoration of joint function. Aspiration of fluid in the convalescent period may relieve pain and aid in restoring motion. Physiotherapy and manipulation after the active phase may help to salvage the joints. Capsulotomy, tenotomy, and/or osteotomy are of value in some cases. Arthrodesis, which is helpful in some instances, is often contraindicated when multiple joints are involved. Modern reconstructive surgery may be used, including pseudoarthrosis, the Batchelor resection, Milch resection, and combined Shanz angulation osteotomy. Arthroplasty is not recommended in children because of possibility of arrest or distortion of growth.

Ten cases are described which were treated in the clinic in the past 7 years. Ages at onset ranged from 2 to 13 years. In 5 cases onset had been preceded by respiratory infection; 2 patients had cardiac involvement, 1 showed hepatomegaly, and 2 splenomegaly symptoms on admission. Treatment consisted of rest in bed during the acute phase, and splinting and physiotherapy as indicated to prevent deformity. Initially, steroid therapy was administered

to the patients until remission of symptoms. All foci of infection were eradicated, and general good health maintained, with correction of anemia. This therapy was followed by prolonged orthopedic follow-up to prevent or correct deformities.

Rheumatoid Arthritis in Children: A Clinico-Roentgenological Study, E. Sairanen. Acta rheum. scand. Supp. 2, 1958. 79 pages.

The progressive development of arthritic changes in the body, as revealed roentgenologically, together with a study of a series of 100 children with rheumatoid arthritis, are discussed in detail in this monograph.

The arthritic process is localized in the soft tissue of the joint, the synovial membrane being involved first, then spreads along the joint surface and proliferates the subchondral area in the bone marrow, destroying the articular cartilage, and narrowing the joint space. Changes in cartilage and bone occur more slowly in children than in adults, as observed roentgenologically. These roentgenologic changes are of six types. *Osteoporosis* is frequently the first roentgenologic observance; it occurs some months after onset in children. *Periostitis* frequently takes place in metacarpal and metatarsal bones, in proximal phalanges and in distal heads of the ulna or radius, generally only on one side of the bone. It may develop in 18 days to 2 or 3 months after onset.

Changes in joint space, with cartilaginous thinning may be an early observation. *Erosion* of cortical and subcortical bone of the articular surfaces produces a ragged outline, beginning usually at the joint margins. Erosion in finger and toe joints is in juxta-articular location, a phenomenon not noted in other joints. The erosion may occur 5 months after onset of the disease, or earlier. In adults the erosion appears early in the distal head of the metatarsal. *Changes toward a stage of stabilization* are manifested when further progress in the joint ceases. During this reparative stage the calcium content of bones generally increases, substantia compacta covers the eroded area, and erosion is transformed from destruction into a deformans type. With disappearance of articular cartilage, ankylosis follows, especially in joints of slight mobility; or ankylosis may occur in one or more joints. *Growth disturbances* result from accelerated epiphyseal ossification, or deformity may arise from uneven growth of the epiphysis.

Changes in the knee joint, especially if monoarticular, may be misdiagnosed as tuberculosis of the knee. In some children premature ossification occurs in the affected knee; in others the epiphyses and patella grow much larger. Changes in ankle and foot are common—some writers state they occur in 40 to 60 per cent of cases. External factors, such as weight, may cause development of deformities. The ankle bones and metatarsus may become fused into a single bone.

In this series of 100 children, onset of rheumatoid arthritis occurred before the age of 15; few were less than 1 year old. In one child onset occurred at the age of 9 months. In 23 patients onset of the disease had been preceded by some other disease, frequently a respiratory infection. The process started slowly in 51, and suddenly with fever in 49, and usually began in a distant joint, unilaterally or bilaterally. The ankle or knee joint was affected initially most often in patients under 6 years of age; in the finger joints if over 10 years old. The disease process progressed to various joints—to the ankle in 50 cases, the toe joints in 55 and the knee in 84. Many joints became ankylosed. Deformity developed in hands and feet; hallux valgus in 17 children, digitus malleus in 14, pes calcaneus in 5 children. Leukopenia occurred in 30, leukocytosis in 19

patients. Proteinuria appeared in 12 patients, but may have been due to gold therapy.

Cartilaginous or bony changes occurred in the talocalcaneal joint in 22 patients and in the talonavicular joint in 14 patients. Otherwise, narrowing of joint spaces was the most frequent observation. In general, narrowing of joint space appears more than 1 year after onset of the disease, and erosion more than 2 years after onset. Erosion occurred in only 3 patients, but ankylosis was comparatively common. Downward subluxation developed in 6 children.

In those cases wherein changes in cartilage and bone were shown roentgenologically, duration of the disease had been generally longer than 5 years. The distal joints of the toes were in general not affected, in contrast to the fingers where such changes were frequent.

Gold or hormonal therapy was used in these patients, with physiotherapy and operative treatment in crippled cases.

DERMATOLOGY, ALLERGY & FUNGUS DISEASES

Critical Evaluation of the Effects of Steroid Lotions on Inflammatory Dermatoses. I. L. Schamberg, S. I. Askovitz, and M. Greenberg. Arch. Derm. 78: 490-99, 1958.

Topical steroid therapy is being widely used in the form of ointments, lotions and creams in treatment of inflammatory dermatoses. A group of 510 patients with various types of dermatitis were treated with a topical steroid lotion. A double-blind paired-comparison method was used to determine the effect of three steroid lotions as compared with a control lotion. Since relatively common dermatoses such as pruritis ani, vulvae, and scroti usually respond to steroid therapy, such cases were excluded from the study.

When the results in 177 patients treated with a 0.1 per cent fludrocortisone lotion were compared with those who received a control lotion (placebo), no statistically significant difference was found. The same negative findings were recorded in 217 patients who received 0.1 per cent fludrocortisone lotion compared with those who received 0.1 per cent hydrocortisone lotion. Also, no significant difference in effects was found in 116 patients who were treated with 1.0 per cent hydrocortisone lotion and those treated with 1.0 prednicortisolone.

Steroid therapy is effective in only a limited number of selected dermatologic patients, and is dependent upon the degree of inflammation, its location, and other factors. This analysis demonstrated that although topical steroid therapy is known to be effective in certain dermatoses, this therapy in a wide variety of dermatoses is no more effective than the control base. When used indiscriminately, steroid therapy is usually ineffective.

Dermatologic Use of Baths, A. G. Franks. Amer. Practitioner 9: 1998-2000, 1958.

Baths are used in treatment of dermatologic patients to incorporate medication, and for sedation of tense patients. They are of value in cases of acute pruritic dermatoses, not only because the relaxation relieves symptoms, but they are helpful in removing crusts and debris. They are not widely used outside of dermatology and a few other specialties. Bath therapy is indicated in diaper rash and intertrigo since they occur in inaccessible areas.

Four types of baths are in general use in dermatology:

1. Potassium permanganate baths are prescribed for treatment of foul smelling or vesicular dermatoses, particularly exudative, and bullous skin disorders. One teaspoonful to 1 tablespoonful (5 to 15 Gm.) of the crystal are used in a tub of warm water. All crystals must be dissolved, or

they will burn. Discoloration of tub and skin is the chief disadvantage.

2. Tar baths are antipruritic and mildly keratolytic. They are most frequently used in the form of coal tar and oil of cade emulsions. They are valuable in treatment of chronic dermatoses and have a stimulating, antieczemous effect. It is uncertain whether the stainless coal tars are as effective as the crude products.

3. Colloid baths are used most frequently. They relieve irritation, inflammation, and pruritic conditions of the skin. They are used also in diaper rash, intertrigo, atopic dermatosis and exanthemas. They are prepared from cornstarch, oatmeal, and other colloids of low viscosity but are less effective than gels of higher viscosity. Colloidal oatmeal (Aveeno) is now available in a concentrated starch-protein complex of oat grain. It is dispersible in water and is a highly viscous gel used without boiling. It is used in cases where soap is contraindicated. Aveeno oilated is another product for use in subacute and chronic dermatitis where a high degree of emolliency is desired. It contains colloidal oatmeal plus a mixture of emollient oils. Large amounts of liquid oil are present but it powders easily and is dispersible in water.

4. Emollient oil baths are used to soften and lubricate dry, scaly or lichenified skin.

A study is reported of 44 patients given bath therapy. Of these 12 had dry skin (xerosis) and 9 had senile pruritis who were treated with specific medications along with bath therapy. The remainder received colloidal emollient baths. Included diseases were winter itch (5 cases); psoriasis, seborrheic dermatitis, and atopic dermatology (4 cases each); icthyosis (3 cases); eczematous contact dermatitis (2 cases); intertriginous dermatitis (1 case). All patients improved with bath therapy.

For patients with dry skin or senile pruritis the baths were used as a prophylactic measure instead of soap and water baths. For the other patients baths were used as a therapeutic measure, one daily or one every other day. The new colloidal emollient baths appear to have a desirable soothing and emollient effect in many dermatologic problems. Since they provide an unusually wide degree of safety along with relief of symptoms, these baths can be used to good advantage in many pediatric dermatoses as well as in patients of advanced age.

Evaluation of a New Oral Antipruritic, V. F. Grieco. Internat. Rec. Med. 171: 618-20, 1959.

A new phenothiazine derivative, trimeprazine (Temaril®), administered orally in tablet form, has been reported to have a marked antipruritic effect in certain dermatoses. A study was made to determine whether this drug will control itching, particularly in patients suffering from pruritus ani. A group of 47 patients were treated; 35 had pruritis ani, 7 had neurodermatitis, and 5 had other forms of dermatologic disorders. They received initially 2.5 mg. (1 tablet) three times a day. Dosages were then adjusted according to responses to the drug. Ten of the 47 patients previously had received antipruritic therapy, including topical steroids, but without success. In addition to trimeprazine, 20 patients received a topical steroid, 1 a topical antihistamine, and 1 an ataraxic. Treamtment extended from 3 days to 2 months. The effects of treatment with these additives were compared with those from use of trimeprazine alone.

Of 25 administered trimeprazine only, results were excellent in 14 patients (56 per cent), good in 9 (36 per cent), without benefit in 2 (8 per cent). Of 22 patients who received trimeprazine and concomitant antipruritic therapy, excellent results were obtained in 11 (50 per cent), good in 10 (45 per cent), without benefit

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in 1 (5 per cent). Thus of the total group, 53 per cent had excellent results, 40 per cent had good results; 7 per cent poor results. About an equal percentage of patients receiving the drug alone and patients receiving both trimeprazine and oral or topical medications, benefited, leading to a conclusion that trimeprazine was the decisive antipruritic agent. The only side effect was a mild drowsiness lasting not more than three days.

Further trials will be necessary to determine whether trimeprazine actually controls itching in general, but this experimental study indicates that the drug substantially reduces itching associated with infection, contact dermatoses, and surgery.

Use of Triamcinolone (Aristocort) in Selected Dermatoses, B. Kanee. Canad. M. A. J. 79: 748-51, 1958.

Search continues for potent adrenal hormones which will have a maximal anti-inflammatory and antiphlogistic effect, yet will manifest few or none of the known complications which followed steroid therapy. Clinical investigations of a new synthetic steroid triamcinolone (Aristocort) which is 9-alpha-fluoro-16^3-alpha-hydroxy-prednisolone, are reported in treatment of several types of dermatoses. Earlier reports were made by other writers of its successful use in treating intractable, generalized psoriasis and alopecia areata. Pre-treatment examinations included complete blood counts, sedimentation rate, hematocrit reading, fasting blood sugar, and serum sodium and potassium estimations. Blood pressure and weight were recorded and any past history of peptic ulcer and diabetes.

In 2 cases of lupus erythematosus and 1 case of scleroderma steroid therapy had been used previously. Comparisons made between the effects of Aristocort and those of prednisone (Meticorten) and methyl-prednisolone (Medrol), showed that the new drug was tolerated as well as the other older drugs. Complete failure in two cases of dermatitis herpetiformis following use of triamcinolone may have been due to inadequate doses. A favorable influence was noted in treatment of two cases of extensive alopecia areata of the scalp.

Six cases of extensive and pruritic psoriasis showed prompt relief of the pruritis in initial doses of 16 mg. triamcinolone. Lesions reappeared when the dosage was lowered but were unassociated with pruritis. With involution or near involution of the lesions maintenance dose became 8 to 12 mg. with continued improvement. In one patient symptoms of development of a gastric ulcer, without radiographic evidence, caused stoppage of the drug. The symptoms of ulcer then disappeared. Another patient with similar gastric symptoms when pruritic symptoms reappeared with a stoppage of the drug, begged for further treatment. Started again on 12 mg. daily, he again made progress, with no further gastric symptoms.

None of the six patients showed laboratory evidence of electrolyte disturbance, change in fasting blood level or hypertension. Only minor side reactions occurred in four patients. Triamcinolone apparently has a potent anti-inflammatory and antipruritic effect.

The Association of Psoriasis with Blood Groups, G. K. Hargreaves and F. F. Hellier. Arch. Derm. 78: 438-39, 1958.

Conflicting reports have been made regarding association between blood groups and psoriasis and other skin diseases. The blood groups of 200 patients with psoriasis were compared with a large control series of persons. The striking similarity found between blood groups of normal persons and those of patients with psoriasis showed clearly that no significant association exists between psoriasis and any specific blood group.

DIABETES, GANGRENE

Obesity and Diabetes, J. M. Strang. Amer. J. Med. Sc. 236: 405-18, 1958.

The rate of exchange of mass and energy in a normal body is tremendous. Carbohydrates, taken in two or three times daily at 3 to 6 hour intervals, are digested and absorbed in about 2 hours. Part of the carbohydrates is oxidized and part is stored as fat and glycogen. Normally, blood sugar amounts to approximately 100 mg. per 100 ml., and the circulating blood volume is about 5 L.; approximately 5 gm. of glucose are in active circulation most of the time. In the normal person 2,000 to 3,000 calories are burned daily, depending on the body type and activity. The turnover is about 5 per cent of the body mass.

Fuel for energy comes from both the carbohydrate system and the fat system; if one fails the other must meet the demands of the body. In order that the metabolic load be met, these two systems normally cooperate.

In the daily overturn of mass and energy, 300 to 500 gm. of carbohydrate are handled without strain, but the carbohydrate handling capacity can be influenced by such factors as training, infection, trauma, muscular activity, and overloading. The carbohydrate system responds more readily than the fat system to sudden loads. The overall fat handling capacity is influenced by similar factors. The inter-relationship existing between the carbohydrate handling capacity and the fat handling capacity is governed by the fuel needs of the body.

In obese persons the rates of mass and energy exchange are increased, so that adaptations to carbohydrate and fat fuel must be made. The intake mass may be 50 per cent greater than normal. The basal metabolism becomes elevated because of the much larger mass of carbohydrate exchange. An intake of 300 to 500 gm. of carbohydrate per day is not unusual.

The obese diabetic, usually over 40 years old and of the anemic type, consumes a diet high in carbohydrates and low in protein. The body is unable to handle the load of carbohydrate metabolism thrown upon it at a given time and the carbohydrate handling capacity is diminished below body needs. The storage mechanism is unable to remove the sugar from the blood as fast as it is poured from the intestine. A diagnosis of diabetes is made when laboratory findings indicate a less than average carbohydrate handling capacity. Strain is produced when this reduced carbohydrate handling capacity coincides with some condition which abruptly increases the carbohydrate load (such as infection), or overloading through dietary indescretions. If the carbohydrate handling capacity continues to be lower than average, a chronic diabetic state results, because of the storage overloading. The margin of safety becomes narrower with strain, coming from infection, trauma, etc. Decompensated fat-handling capacity leads to ketonia and the acidosis increases.

Treatment of obese diabetics calls for lessening of strain on the carbohydrate handling capacity by reducing carbohydrate exchange, or by improving the ability of the body to handle the excessive load through the use of insulin. This will reduce the total metabolic load. In addition, the body must be adapted to obtaining a higher proportion of its energy from the fat fuel system, by reducing the load on the carbohydrate handling capacity. The use of Orinase is suggested for this purpose.

Most obese diabetics can attain a body of normal proportions, normal mass and energy exchange by a prolonged adherence to a proper reduction regimen which provides a carbohydrate handling capacity well above immediate body requirements.

Diabetic Neuropathy Precipitating After Institution of Diabetic Control, M. Ellenberger. Amer. J. Med. Sc. 236: 466-71, 1958.

Insulin was formerly suspected of being

the etiologic, toxic agent in causing diabetic neuropathy. But this disorder does not occur only during a prolonged period of uncontrolled diabetes, as generally thought. This is demonstrated in 4 cases reported here which showed no signs or symptoms of uncontrolled glycosuria. These 4 patients illustrate onset or acute exacerbation of neuropathy *after* control of hyperglycemia and glycosuria through use of insulin and proper diet.

That insulin has not been the etiologic agent is indicated by the following facts: (1) The neuropathology following institution of insulin control of diabetes is found to be identical with all types of diabetic neuropathy (symptoms, signs, spinal fluid findings, and course of the disease). (2) Neurologic symptoms may disappear while the use of insulin is being continued. Therefore, it is not a drug induced condition. (3) Attempts to control the diabetes by other measures than insulin therapy can cause precipitation of neuropathy.

Therefore, insulin is not the noxious agent. It acts instead as the medium for control of diabetes which in some cases leads to neuropathy. Also, in some cases neuropathy following insulin control was attended by hypoglycemia. But the hypoglycemia was transitory and unrelated to the diabetic neuropathy. The etiology remains obscure. It is suggested that a sudden change in homeostasis may produce a stress phenomenon, since stress situations (coma, surgery, infection, trauma) have been immediately followed by onset of neuropathy in the diabetic patient.

Unsuspected Diabetes Mellitus in Peripheral Vascular Disease, C. C. Bartels and F. R. Rullo. New England J. M. 259: 633-34, 1958.

All patients showing evidence of peripheral vascular disease should be thoroughly tested for abnormal glucose tolerance. Frequently patients with peripheral vascular disease of the lower extremities will be found to have a previously unsuspected case of diabetes mellitus. In a study of 100 such patients, aged from 27 to 85 years, who all had pain of claudication and some complained of paresthesia, pain at rest, nonhealing ulcers and even gangrene, examination showed absence of one or more pulses in the lower extremities in every instance. In addition, each patient showed one or more radiologic signs of arterial insufficiency: rubor, delayed venous filling, blanching of elevated extremities, ulceration, and calcification of the blood vessels; and arterial occlusion in 32 of 33 patients having femoral arteriograms.

In 20 per cent of cases evidence of diabetes mellitus was undeniable, and 23 additional showed abnormal results on glucose tolerance tests, or a total of 43 per cent in whom a diagnosis of diabetes might be considered. In another 12 per cent in whom the one-hour test showed elevated blood sugar levels, further study seemed indicated. Only 23 per cent of the entire group showed entirely normal results of the test.

MEDICAL PRACTICE

Influence of Malpractice Suits on Surgery, J. W. Watts. Amer. Surgeon 24: 784-86, 1958.

To determine the effect of malpractice suits on surgery, a survey was made of a few general surgeons, neurosurgeons, orthopedists, chest surgeons, specialists in obstetrics and gynecology, anesthesiologists, a plastic surgeon and a roentgenologist. A few surgical procedures have been affected by malpractice suits. Aortograms have been avoided in some cases because of the possibility of fistula formation. Simple total hysterectomy has been substituted for radical hysterectomy in cases of carcinoma. Because of a damage suit two neurosurgeons no longer cut out the vestibular nerve for Ménière's disease. In one instance the

surgeon refused to perform a certain operation because the patient was threatening suit against another surgeon. In another case where relief could be obtained through surgery, the surgeon recognized that the patient's family was demanding complete relief. Spinal anesthesia was not being used by some because of malpractice suits. Use of roentgenotherapy in certain serious cases was given up because of court decisions.

In general, it seemed that the harmful results outweighed the good. One desirable effect of study of malpractice suits might be that doctors may be caused to re-evaluate certain procedures, and attempt to improve them. It was emphasized that doctors should spend more time explaining to patients and their families the possible complications and risks attending certain procedures. In elective surgery, the patient should help make the decision.

The additional tests, consultations and roentgenograms now required are an added expense to the patient. The greatest harm from malpractice suits is their tendency to retard medical progress, and set up barriers to satisfactory doctor-patient relationship.

How to Avoid Medico-Legal Problems, F. Evis. Canad. Hosp. 35: 51, 82, 96, 1958.

In this series of papers regarding medico-legal problems met in hospitals, part of the discussion relates to Canadian laws regulating hospitals. Certain parts of the article relate to hospitals everywhere and concern obtaining consent of the patient, responsibility of the hospital in negligence charges, necessary secrecy regarding hospital records, preventive measures in the operating room, and care of suicidal patients.

The consent of the patient must be obtained to perform an operation and a biopsy. Unless the situation is explained before operation in non-technical language, the type of operation to be performed and probable risks, the patient may later charge malpractice. Operations can be extended beyond such consent if legally justifiable because otherwise the health or life of the patient is endangered. In an emergency considerable latitude is permitted the surgeon in exercise of his skill and judgment. It is always wise to also obtain the wife's or husband's consent. It is advisable to get the patient's consent if moving pictures or slides are to be made for teaching purposes, and authorization to use them for scientific purposes only, for publishing them in medical journals, or for professional exhibits.

The hospital cannot compel a patient to undergo treatment if he refuses his consent; he should sign a release (if of sound mind), relieving the hospital and its staff from liability that comes from lack of the recommended treatment. However, if an emergency demands a blood transfusion to save life, the hospital and doctors may proceed. The hospital may be held liable if any damage is caused by negligence on the part of any member of the hospital staff during the course of hospital duties. The hospital is not liable if the doctor and/or nurse were engaged by the patient and are to be paid by the patient. The hospital is liable for negligence in carrying out routine orders by a nurse on the staff. The hospital is not responsible if special duty nurses are employed by the patient but is responsible if she is engaged by a doctor on the staff without consulting the patient.

Neglect of any of the following precautions can cause involvement of the hospital in a medico-legal case which might have been avoided. Hospital records must be kept secret and this should be known by every doctor, nurse and layman on the staff. A minimum number of persons should have access to the records. They should not be produced on request of any staff member without proper authorization. Information regarding x-ray and laboratory findings should not be given over the telephone unless the identity of the in-

quirer is positively known and it is known that he is legally entitled to the information.

Drugs, narcotics and all medications should be kept safely and should be handled with utmost care to prevent harm. The hospital must take every precaution against spreading infection.

Laws regarding the condition of the operating room are strict. Laws must be obeyed regarding prevention of fire and explosions by proper construction of the room and adjacent rooms, and have adequate grounding devices. Conductive footwear and proper clothing must be worn; non-combustible anesthetics used when electric cautery is called for; woolen blankets cannot be used in the operating room. All equipment, appliances and instruments must be inspected routinely and periodically, and all found defective removed or repaired. Care of dangerous equipment should be entrusted to qualified persons who are alert to possible accidents during its use.

Another problem is the suicide or attempted suicide. The hospital cannot be charged with neglect if possibility of the act was not anticipated by a competent doctor or nurse. If the case history or condition causes such suspicion the hospital must take reasonable precautions against injury or suicide. The police must be notified if there is a certainty that suicide was attempted; if this can be proved to be wrong, the doctor may be sued for defamation of character; if not reported to the police, there may be grounds for a finding of negligence on the part of the hospital and its staff.

Every hospital should have its lawyer to consult when any legal implications arise concerning an act of the administration, the Board, or any member of the hospital team. Practical rules laid down by the hospital will help to prevent unfortunate mistakes in judgment of a staff member who may be working under pressure of circumstances, perhaps during the night when the staff member is already exhausted.

MUSCULOSKELETAL DISEASES

Is the Cause of Pes Valgo-Planus ("Flat Feet") Unknown? S. J. Wikler and T. Hale. Military Med. 124: 591-98, 1959.

The brief instruction given in medical schools regarding chronic foot disorders affords the average physician little information about these diseases. Few orthopedists have undertaken studies concerning lasts, shoe construction and shoe fitting, yet they are regarded as authorities on foot diseases. Their experience is largely in the field of fractures, deformities from trauma, poliomyelitis, cerebral palsy and other orthopedic conditions in which chronic foot diseases play only a small part. During a 5-year period the *Journal of Bone and Joint Diseases* published 904 articles, only 7 of which were on "flat foot" and 3 of them were brief descriptions of surgical procedures. The cause of flat foot remains unknown even to chiropodists. They are concerned chiefly with treatment and not particularly with prevention of fallen arches.

The extensive literature about the foot does not establish what constitutes a disabled foot, its cause and prevention, and proper treatment. No acceptable terminology has been found for what the public calls flat foot, fallen arches, or broken arches. Technically this disorder is termed imbalanced foot, static pes valgo-planus, abducted foot, flexible flat foot, unstable foot, and weak foot.

The many theories regarding the cause of this disorder are reviewed together with the objections that have been made to each theory. Whether all feet are normal at birth or have a developmental weakness, whether the weakness, which led to flat feet, is congenital or acquired because of hard pavements which are trodden or overlong periods of standing, or whether weak foot results from eating processed or re-

fined foods, or whether the weakened foot arises from chronic nervous exhaustion, or whether a disordered foot follows sicknesses such as pneumonia or injuries such as sprained ankle, all these theories have their advocates. Whether bad posture is a cause or a result of pes valgo-planus is another disputed theory. Obesity and malnutrition are also held to blame. Whether shortened heel cords and relaxed feet are anomalies with which a child is born, or whether children acquire shortened heel cords through use of confining bedclothes is another dispute.

That primitive peoples and other nonwearers of shoes have none of the usual foot disorders is held by many as proof that shoes are the chief cause of flat foot. Yet none would say that man should expose his foot today to the weather, hookworm and other diseases, and possible injuries. Since treatment of foot diseases depends largely upon what is considered the cause, various types of arch supports have been designed and worn whether needed or not. Some writers claim the shoe heels throw the feet off balance and heel-less shoes should be worn, while some advocate wearing of heels but they should be shaped to coincide with the natural rocker action of the foot.

Shoes with pointed toes have been long condemned, because the toes are immobilized and the body tries to compensate for squeezing of the toes, but the pointed toe is in fashion again. Foot troubles increase with fancy styles of shoe. Between 1890 and 1913 arch disorders bringing patients into the hospital increased from 2.6 per cent of admissions to 29.2 per cent. The fact is rarely mentioned that shoes usually are too small and hardly ever the shape of the foot. Studies have been reported of foot disabilities in thousands of persons, but little notice is taken of strength of the toes, the ability to spread the toes, compression of the toes by shoes, or the density of the musculature on the plantar surface of the foot.

During the past decade seven hundred million dollars have been set apart for research on the cause of chronic disease. Review of the literature shows that no grant, however small, has been allotted to determining the causes of the common disabled arch of the foot. In the great work of the National Institutes of Health no one seems interested in the foot. The authors believe that the modern shoe is the basic cause of foot trouble, but whatever the cause, the causative factors should be determined. They feel that a comprehensive research effort by the national health agencies or by privately endowed institutions should be made, to solve the enigma of so many fallen arches in modern times.

NEW GROWTHS

Nevi: Clinical and Pathological Evaluation, Nickel, W. R. Plastic & Reconst. Surg. 22:123-38, 1958.

Among the many types of pigmented lesions are: lentigo, a permanent freckle occurring on the lip of an adult, and a multiple familial form appearing on the mucous membrances of the mouth. Senile lentigo (liver spots) occurs particularly on the back of the hand after the age of 40.

Benign pigmented nevi contain nevus cells. The junctional nevi show nests of altered cells at the epidermal-dermal junction. Most nevi of children are of this type. They diminish in size as a child grows, except for some occurring on the hands and feet where junctional activity continues throughout life. Dermal or interdermal nevi form especially on the face, and may show no evidence of pigment formation. Juvenile prepubertal melanomas, or psuedomelanomas, contain no hair and often are of short duration. They are pinkish red or reddish brown nodules; microscopically at first they may seem mildly malignant. They are benign; microscopic observance of the presence of myogenous

appearing cells helps to establish the diagnosis. In juveniles it is difficult to differentiate between benign and malignant forms. There has been a growing number of deaths reported from malignant melanomas in children.

Lentigo maligna, or active junctional nevi, are flat lesions variously pigmented, appearing at any age but mostly later in life. They enlarge slowly, darkening in color. After several years (about 5 years), growth is observed within the pigmented area. Microscopically, early over-activity of clear cells in the basal layer without formation of true nests may be seen, which is characteristic of junctional nevi. These lesions should be considered malignant melanomas at onset.

Blue nevi and cellular blue nevi develop oftenest on the hands and feet. The blue color varies with the depth of the lesion and degree of fibrosis. Cellular blue nevi show nests of cells with little pigment. They occur frequently on the buttocks. Blue nevi on the toe in close relationship to the nail is difficult to diagnosis differentially.

Malignant melanoma or premalignant lentigo maligna is an upward growth of cells, heavily laden with pigment in early lesions. Seborrheic verruca are often diagnosed clinically as malignant melanoma if solitary. Pyogenic granuloma of the hand or foot is always suspected of being a malignant melanoma. The histopathologist evaluates individual cellular changes in which he suspects malignancy. He is influenced by the grouping, pattern, and arrangement of microscopic changes.

Forty-three different conditions are listed which clinically have been misdiagnosed as nevi; also 17 different conditions microscopically misdiagnosed as malignant melanoma. All were found to be benign. Ninety per cent of the specimens clinically misdiagnosed as nevi fell into the following three categories: (1) pigmented lesions containing melanin—seborrheic keratoses, epithelial nevi, basal cell carcinoma, neurofibromas, soft fibromas (cutaneous tags); (2) pigmented lesions containing blood—pyogenic granuloma, hemangioma with thrombus, cavernous hemangioma, thrombosed varix, sclerosing hemangioma, verruca; (3) pigmented lesions containing fats—xanthomatous histiocytoma, fibroxanthoma, xanthoma.

It is generally agreed that a benign melanoma does not become malignant. A traumatized benign pigmented nevi may crust over and bleed and suggest malignant degeneration. Some regarded as doubtful do become malignant. They may be lentigo maligna.

The author does not share the belief that biopsy of suspected cutaneous melanomas should not be performed. But operation may be too late if the patient must wait for microscopic examination. If malignancy is suspected, primary surgical excision is the treatment of choice. The changes which cause suspicion of malignancy are an increase in pigmentation, changes in the character of the mole, color changes suggesting pyogenic granuloma, and local subjective awareness, such as itching. Malignancy may be presumed if there is nodular elevation of a flat mole; crusting and oozing; satellite pigmentation; spontaneous bleeding; accelerated growth; erythematous halo around the nevus; ulceration. Some malignant melanomas show none of these changes nor arouse suspicion. For that reason biopsy of all treated lesions is strongly recommended.

SURGICAL ARMAMENTARIUM

DuraFoam: A New Material for Making Splints, J. N. Swanson. Canad. J. Occupat. Ther. 25: 85-89, 1959.

Use of rest splints may prevent or even correct deformities which are secondary to muscle spasm and contractions, for example, in neurological conditions such as

poliomyelitis and hemiplegia, especially if physiotherapy is not started until the disease process has ceased. Splints are helpful even in cases of arthritis, for it is not cured by drugs; asprin, Butazolidin and steroid hormones are merely palliative, and help the patient perform therapeutic exercises. Despite intensive drug therapy and exercises, splinting may be required to prevent deformity.

The usual splints used tend to be difficult to apply, messy, and heavy. DuraFoam is described as a new plastic used for forming splints which are light, weighing about 2 ounces, snug-fitting and comfortable. They are stronger by weight than other plastics, are rapid in setting, but easy to mould, and can be heated and remoulded. Further advantages are that it is washable as a splint, waterproof, and unaffected by oil, alcohol, ointments and secretions. It is non-inflammable, and transparent to x-rays. Furthermore, it is insulated and cool, shock-resistant, and resilient, nontoxic and allergy-free. The material comes in attractive colors, and is inexpensive.

The material is supplied in two parts: two chemicals which when mixed form foam, and a plastic bag with a soft inner lining. The slight heat generated gives a comfortable feeling and promotes relaxation of spasm. A description is given for preparation of and applying the splint.

MISCELLANEOUS

Shoe-Fitting Fluoroscopes: Their Outlawing in Pennsylvania, J. Lieben. Amer. Indust. Hyg. Assn. J. 19: 382-83, 1958.

These devices which cause a high radiation exposure to feet of unsuspecting persons are most often operated by untrained personnel. Because these machines are a source of unnecessary radiation exposure, a law was passed late in 1956 in Pennsylvania, dealing with all phases of ionized radiation, and early in 1957 an amendment outlawed use of shoe-fitting fluoroscopes. The law limited maximal permissible dosage for occupationally exposed persons to 300 mr of total body radiation. The maximal permissible amount for feet and ankles was five times this limit. Generally, the public received only one-tenth of this amount.

At the end of 1957 there were still 22 states with no regulations, except possibly for signs warning the public. New York State allows use of the machines by persons licensed to practice medicine, dentistry, podiatry, or osteopathy. The Pennsylvania law also grants permission to the healing professions. The law overlooked one danger. A large percentage of the Pennsylvania fluoroscopes went into neighboring states. Two were found in high school physics departments. Some may be in private homes.

"The good opinion of the public ought never to be lightly esteemed."

Cicero

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

CALIFORNIA

Dr. Robert L. Brennan of Los Angeles was tendered a testimonial dinner at the Hollywood Roosevelt Hotel on November 11. Awards were presented by Harbor and

Southern Division of the California Podiatry Association. A gavel was presented by Dr. Emma Anderson of Los Angeles and Los Angeles City and County each presented Scrolls of Commendations. Illustration shows Dr. William F. Eads, President of the California Podiatry Association (l), presenting plaque of commendation to Dr. Brennan. Dr. Brennan was honored for his 22 years of progressive practice and for his many activities in the Association in local hospitals and for his contributions to the art and science of podiatry as an instructor and author, by his many friends in podiatry and medicine.

ILLINOIS

Zone III

Zone III of the Illinois Podiatry Association held an interesting meeting on December 6, 1959 at the Orlando Hotel, Decatur, Illinois. Dr. John Graham of Decatur, Program Chairman, arranged for guest speaker D. D. F. Alexander of Cicero, who spoke on "Practice Development," pride in

Awards for Research Papers

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Application forms, rules and regulations can be obtained from the Secretary. The final date on which papers will be accepted is May 1, 1960.

our profession, isolated techniques in practice and his evaluation and comments on use of the Syncardon machine.

The next meeting is scheduled to be held in Springfield, Illinois, March 6, 1960. Dr. Irving Dunas will act as Program Chairman.

MASSACHUSETTS

At the annual meeting of the Massachusetts Podiatry Society, held on October 4, 1959, the following officers were elected: President, Maxwell P. Zide; 1st Vice President, Albert B. Reiss; 2nd Vice President, George Haigh; President-elect, Anthony Polom; Executive Secretary-Treasurer, Sidney G. Holmes.

NEW YORK

New York Launches Labor Program

A comprehensive podiatry labor program was launched in New York State at a dinner at which the Podiatry Society of the State of New York acted as host to more than 40 labor officials representing every major international labor union.

Dr. Milton Werbel, President of the Podiatry Society, Dr. Ernest Weiner, Labor Relations Chairman and Mr. Gilbert Hollander, Executive Secretary, gave short talks to the labor group on the background of podiatry and the important role which the podiatrist can play in assuring complete health care for the union member.

A resolution to be submitted to the New York State AFL-CIO convention calling for foot care and podiatry inclusion in all health insurance contracts was unanimously approved by the labor representatives present. Several unions agreed to co-sponsor this resolution.

Heading a special podiatry Labor Advisory Committee was Mr. Tom Duffy, Assistant to the President of the International Longshoreman's Association. The Labor Advisory Committee will work with the Podiatry Society in planning a Labor Foot Health Month and special projects designed to acquaint the several million union members in New York State of the importance of proper foot care. Stories and pictures were carried in the metropolitan newspapers and the labor press.

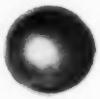
PENNSYLVANIA

South Central Division

The South Central Division of the Chiropody Society of Pennsylvania held a membership dinner meeting on November 24, 1959. A panel discussion was held to enlighten members and non-members concerning the activities of the society and state board. The panel consisted of Dr. Jack Pincus, President of the South Central Division and Secretary of the Pennsylvania Chiropody Board of Examiners; Richard C. Hess, Executive Secretary of the Chiropody Society of Pennsylvania; and Dr. William Jeffery of York, Pennsylvania, who acted as moderator. Six non-members who attended made known their desire to become active members of the society.

THE FUNGUS DIAGNOSTIC SERVICES

Before Inoculation



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- **Prepared Plastic Plates for Culture Inoculation.**
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- **Sample with chart for identification on request.**
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SOUTH CAROLINA

Dr. James D. Hill was re-elected President of the South Carolina Podiatry Society at the business meeting held in the Wade Hampton Hotel in Columbia. Other officers elected were Dr. James Rice, 1st Vice President; Dr. Gene Clark, 2nd Vice President; Dr. H. A. McAninch, Secretary-Treasurer.

TEXAS

At the recent state meeting of the Texas League for Nursing, the Chiropody Society of Texas displayed the A.P.A. Medical-Hospital Exhibit. This was manned during the three-day meeting by Austin chiropodists. Two hundred and twenty-five "Information Kits" were picked up out of the 285 registrants.

The movie on "Chiropody-Podiatry in Hospital Routine" was reviewed by a committee of members of the Texas League for Nursing and a group of staff nurses of the Austin City Health Department. Delegates to the meeting were informed that arrangements can be made for a chiropodist in their locality to participate in the student nursing curriculum to lecture on foot health.

The Nursing Relations, Vocational Guidance and Audio-Visual Committees are planning a very vigorous follow-up program at the local level. The exhibit was managed and manned by Drs. Thomas P. Moriarty, Ed Fisch and Mildred Kraft.

WASHINGTON

At the annual spring business meeting, the Washington State Chiropody Association adopted a new set of bylaws, thereby abolishing a two-division set-up which had been in force for many years. During a special meeting held on November 8, 1959 in Wenatchee, the association changed its name to Washington State Podiatry Association. Plans are under way to properly announce the name change to the public and other medical and professional groups.

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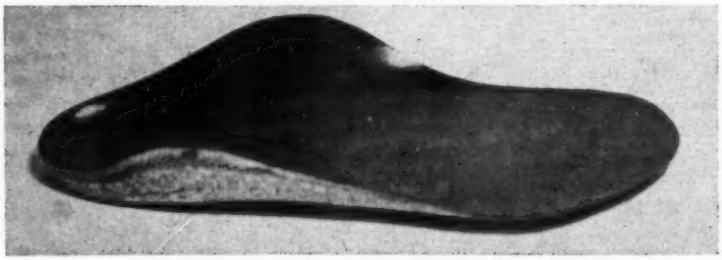

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If you change your address please notify THE JOURNAL at least six weeks before the change is made. Include the address clipped from the envelope of your latest copy of THE JOURNAL, being sure to clearly state both your old and new address. If your city has Postal Zone Numbers, be sure to include this Zone Number in your new address.

"Oh, there you are, Doctor!"

The average person walks six miles a day and bears 700 tons of weight on his shoes, according to the Boot & Shoe Workers Union which further calculates that Americans buy about 600 million pairs of shoes a year.

This new film strip can be presented to your grade school teachers for showing to grades 1 to 3 — Teaches the youngsters about foot health. Kit contains film strip in cannister, teacher's manual, 50 take-home foot health cards, suggestions for distribution. Order from Washington office —each kit $2.50. Additional cards available at cost. This film strip is composed of 30 frames in color with titles on Foot Health. Produced and Distributed by Audio-Visual Council, American Podiatry Association on a grant-in-aid from Foot-So-Port Shoe Co.

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The finest adhesive for felt. It remains flexible.

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Hartford, Conn.

AMERICAN SOCIETY OF CHIROPODICAL ROENTGENOLOGY

At a meeting of the American Society of Chiropodical Roentgenology held at the Waldorf Astoria Hotel in New York, August 29, 1959, the following officers were elected: President, Joseph W. Healy; 1st Vice President, James Bates; 2nd Vice President, William Jeffery; Secretary, Joseph Starr; Treasurer, Nathan Lambert and Member-at-Large, Milton Lewis.

CHICAGO COLLEGE OF CHIROPODY

Dr. Kurt Eichelbaum, Dean of the Chicago College of Chiropody, announced the appointment of Dr. Francis J. Grund to the position of Head of Clinical Chiropody. Dr. Grund, who has served as clinician with Chicago College since 1952, will limit his private practice in Downers Grove to give his full time and energy to the clinics of the college. The results of these energies have already been noted in promising changes in the clinic. Graduated in 1949 from Chicago College, Dr. Grund's wife, Jacqueline, is also an alumna of Chicago College.

LAWRENCE FROST ELECTED MAYOR

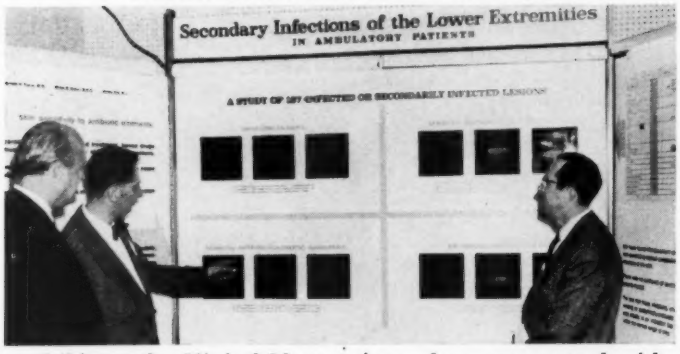
Dr. Frost was elected Mayor of the City of Monroe, Michigan, on December 8th. He had previously served on the Monroe Planning Commission and served a two-year term on the Monroe City Commission.

Dr. Frost is well known to all members of the profession for his contributions to foot surgery from the lecture platform, from the pages of the *Journal* and post-graduate courses.

WOOLF PROMOTED

Effective October 1, 1959, Lieutenant Commander William H. Woolf, MSC, USNR, has been promoted to Commander. Dr. Woolf is the podiatrist at the main Navy Dispensary, Washington, D. C. and recently was appointed Assistant for Podiatry Section Officers in the Medical Service Corps, U. S. Navy.

ASHUR EXHIBITS AT A.M.A. MEETING

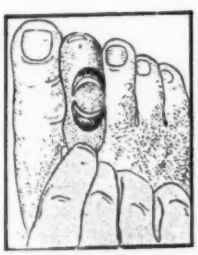


One of the exhibits at the Clinical Meeting of the American Medical Association held in Dallas, Texas, December 1-4, 1959, was "Secondary Infections of the Lower Extremities in Ambulatory Patients" by Milton E. Ashur, D.S.C., and Reginald H. Farrar, M.D., of Jersey City, New Jersey. Shown in the photograph from left to right are Gunther Corssen, M.D., Milton E. Ashur and R. D. Dwyer, M.D.

The theme of the exhibit covered the problems of sensitization and side reactions often encountered with use of topically applied antibiotics. This has stimulated search for a compound which avoids these complications. A new topical microbicide, tricolobisonium chloride, in treatment of secondary infections of the lower extremities had been employed. Results were presented, particularly in treating difficult stasis ulcers. This exhibit was a medal award winner at the Annual Meeting of the A.P.A. held in New York, August, 1959.

FOR THE FINEST IN LATEX SHIELDS

CUSTOM BUILT PROSTHETICS DESIGNED AND TAILORED
BY CHIROPODISTS FOR THE CHIROPODY PROFESSION
TO CASTS OR IMPRESSIONS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TOLEDO HONORS OUR PRESIDENT

On November 12, the city of Toledo proffered a Testimonial Dinner to our President Dr. Marvin W. Shapiro and a First Citizen of Toledo. The dinner was attended by about 500 persons including 70 members and guests from various parts of the country. Honorary Chairman of the Committee was E. J. McCormick, M.D., Past President of the American Medical Association and the guest speaker for the occasion was Mr. Thomas Hendricks, Assistant to Executive Vice President Blaisingame of the American Medical Association.

Other highlights of the evening were short addresses by the Mayor, some of his former teachers and professors, other state and city officials and his two brothers. On behalf of the people of France, Jean D'Esparmet, a French Consul, presented on behalf of the French people to Dr. Shapiro, a very early text on the care of the feet written by Monsieur LaForest, chiropodist to the pre-revolutionary royal French family. Monsieur D'Esparmet (L) is shown in the illustration presenting the text to Dr. Shapiro and Mr. Hendricks (R) looks on.

A new and effective
treatment for onychomycosis

KERALAC

A solution of chloranil (fungicide) in a high grade nail lacquer. The lacquer holds the fungicide on to the nail so that close and intimate contact is assured.

Keralac is cosmetically elegant and when dry has the smooth and shiny surface of a nail lacquer. Further, the painting of a nail with a lacquer is appealing to the patient.

In the office, remove the infected portion of the nail and debride the nail bed. Instruct the patient to carry out the following twice a week:—1. remove old lacquer by nail polish remover; 2. sand the nail down as much as possible; 3. repaint with Keralac.

Available ½ oz. bottles complete with brush applicator.

Samples and literature on request.

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HOSPITAL SERVICE NEWS

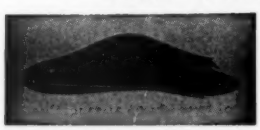
CALIFORNIA

Formation of a new autonomous Podiatry Staff of Doctors Hospital, Los Angeles, with Dr. Robert L. Brennan as its first permanent chairman has been completed with 16 podiatrists so far on its roster. Dr. Sidney R. Bob, also of Los Angeles, was named secretary. It is the first Podiatry Staff, at least in California, to be accepted autonomously by an accredited American Osteopathic Association hospital approved for intern training. On October 27, at its second called meeting, the staff adopted its constitution and bylaws, which had been under study by a special committee. This may be a model for autonomous Podiatry Staffs.

Subject to confirmation by the Staff Executive Committee, the Credentials Committee approves and defines privileges for applicants desiring to practice Podiatry in Doctors Hospital. In addition to Dr. Brennan, the Credentials Committee is composed of Dr. Wilson C. Cartledge of Huntington Park and Dr. Norman R. MacGregor of Los Angeles. Other committee chairmen are: Records Committee, Dr. Robert L. Evans and Dr. Norman S. Grossman, both of Los Angeles, co-chairmen; Tissue Committee, Dr. Emma L. Anderson, Los Angeles; Scientific-Program Committee, Dr. Eugene A. London, Los Angeles.

Working closely with the group in formation of the Podiatry Staff have been Howard B. Norcross, D.O., Medical Director, and Anson Reeder, Management Coordinator, both of Doctors Hospital. A highlight in the new staff's activity was an open meeting on Tuesday, October 27, at which La Moyne Hickman, D.O., chairman and chief of service of the Department of Cardiovascular Surgery at Doctors Hospital, spoke on "Cardiac Arrest." Twenty-seven podiatrists from a radius of 40 miles, attended the meeting.

THE HOUSE OF COMFORT



known for

Their outstanding, skilled craftsmanship in the appliance of old-fashion and modern hand-made foot appliances for any kinds of deformity as well as Balance Inlays, Levy and Sansone Molds, Celastic, and arches of oak sole leather with blue tempered steel springs; also flexible type of supports of cork and rubber.

We also construct any type of stainless steel plates.

The priceless knowledge and experience which we learned and inherited from our fathers enable us to be very proud of our scores of years in orthopaedic work.

Every appliance constructed in our laboratory is hand made. We DO NOT HAVE ANY STOCK APPLIANCES OF ANY KIND.

It is our proud privilege to serve you and the profession in your every need and we look forward to hearing from you in the near future. Write for our literature.

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DEATHS REPORTED

Edward H. Kott
Texas

Thomas H. LeCroy
Sylacauga, Alabama

Ross T. McIntire, M.D.
Chicago, Illinois

Dr. McIntire, former Navy Surgeon General and long-time personal physician to the late President Franklin D. Roosevelt, was an Honorary Member of our National Association. Since 1955, the doctor has been Executive Director of the International College of Surgeons. He was stricken on December 8 with a fatal heart attack.

France A. McKee, Sr.
Ft. Worth, Texas

Dr. McKee, who had helped advance chiropody in Texas for over forty years, died of a heart attack in his office on October 20, 1959. He was past President of the Chiropody Society of Texas and was granted a 25-year Certificate of Membership in the N.A.C. in 1940.

Charles C. Spidle
Flint, Michigan

George W. McClintock
St. Petersburg, Florida

Theodore Ruderman
Mamaroneck, New York

Alexander L. Shapiro
Hollywood, Florida

Dr. Shapiro, 52, died on November 23 in Memorial Hospital. He came to Hollywood, Florida, 14 years ago from Atlantic City, New Jersey. He was a veteran of World War II, a Mason and 32nd degree Shriner. He was a graduate of Illinois College of Chiropody, 1940.

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when each case
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CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
Chicago, Ill., Aug. 27-30, 1960
Drake Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Hartford, Conn., Oct. 21-23, 1960
Statler Hilton Hotel
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
New York, N. Y., Feb. 19-21, 1960
Barbizon Plaza Hotel
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Philadelphia, Pa., May 5-8, 1960
Sheraton Hotel
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Mid-West Conference
Chicago, Ill., Mar. 25-27, 1960
Morrison Hotel
Dr. Ralph M. Ticko, Pres.
536 W. Wisconsin Ave., Milwaukee, Wis.

Region Six
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Omaha, Neb., April 1-3, 1960
Sheraton-Fontenelle Hotel
Drs. Harold G. Wieseman and Ken C. Nielsen
640 City Natl. Bank Bldg., Omaha, Neb.

Region Seven
Sun Valley, Idaho, Sept. 7-11, 1960
Challenger Inn
Gordon R. Tobin, Convention Chairman
153 Third Ave., North, Twin Falls, Idaho

Region Eight
(D. C., N. C., S. C., Va., W. Va.)

Region Nine
(Florida)
Dr. E. B. Hurd, Gen. Chairman
623 DuPont Blg., Miami, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Atlanta, Ga., Oct. 7-9, 1960
Dinkler Plaza Hotel
Dr. Paul Lefkoff, Secretary
202 Burdine Bldg., 849 Peachtree St., N.E., Atlanta, Ga.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
Southwestern Chiropody Congress
Oklahoma City, Okla., June 20-23, 1960
Skirvin Hotel
S. D. Tomlinson, Gen. Chairman
3101 Classen Blvd., Oklahoma City, Okla.

Region Twelve
(Ariz., Cal., Nev., Utah)
Western Podiatry Congress
Long Beach, Calif., May 27-28, 1960
Lafayette Hotel
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

Canadian Podiatry Association
Dr. L. Hurwitz, Exec. Sec.
3017 Bathurst St., Toronto, Ont.

New Mexico Podiatry Society
Carlsbad, N. Mex., Jan. 23-24, 1960
La Caverna Hotel
Dr. Leon Cohen, Program Chairman
306 N. Canal St., Carlsbad, N. Mex.

Attend Your

STATE & REGIONAL MEETINGS

THEN YOUR NATIONAL

IN AUGUST 1960

IN CHICAGO, ILLINOIS

WOMEN'S AUXILIARY MESSAGE

We of the Women's Auxiliary would like to extend New Year's Greetings to all of you and ask that you include in your resolutions to

TAKE TIME FOR 10 THINGS

1. TAKE TIME TO WORK–
   it is the price of success.
2. TAKE TIME TO THINK–
   it is the source of power.
3. TAKE TIME TO PLAY–
   it is the secret of youth.
4. TAKE TIME TO READ–
   it is the foundation of knowledge.
5. TAKE TIME TO WORSHIP–
   it is the highway of reverence and washes the dust of earth from our eyes.
6. TAKE TIME TO HELP AND ENJOY FRIENDS–
   it is the source of happiness.
7. TAKE TIME TO LOVE–
   it is the one sacrament of life.
8. TAKE TIME TO DREAM–
   it hitches the soul to the stars.
9. TAKE TIME TO LAUGH–
   it is the singing that helps with life's loads.
10. TAKE TIME TO PLAN–
    it is the secret of being able to have time to take time for the first nine things.

May all of you have a prosperous and happy year during 1960.

Mrs. Cleotha Parham
President

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FOR TOPICAL APPLICATION

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By Bob Hughes, D.S.C.

OH DOCTOR
DO YOU REMEMBER MRS. ELSIE FLOGGE?
HER?
NO
MARRIED, SIX CHILDREN, RED HAIR, BLUE EYES, THIRTY EIGHT.....
NOPE!
SHE'S SIX FOOT EIGHT, WEIGHS THREE HUNDRED AND THIRTY POUNDS?
I DON'T REMEMBER HER, ANYTHING ELSE?
SHE HAS A NUMBER TEN
OH, THAT MRS. FLOGGE! OF COURSE, WHAT ABOUT HER?
BOB HUGHES D.SC.

MOOD ELEVATORS

Idle thoughts

Remarriage: a matrimonial repeat in which a man discovers there is only one perfect husband—his wife's first mate.

"Where have you been, Johnny?" demanded his mother.

"Playin' ball," replied Johnny.

"I told you to beat the rug."

"No ma'am, you told me to hang the rug on the line and then beat it."

That's the English language.

A Baptist farmer had a mean-tempered cow which he wished to dispose of. A Quaker farmer on a nearby farm needed a cow, hence a deal was made. When the Quaker sat down on his stool to milk the cow she slashed him across the face with her tail. A cow naturally switches her tail to brush off a fly, for example, so the Quaker said nothing. But when the cow stuck her foot in the milk pail and planted the same foot in the Quaker's rib it made him a bit angry. He got up, walked around in front of the cow and looked her square in the eye. "Friend," he said, "I cannot hate thee, for I am admonished to love thee. Neither can I strike thee, for that would be a sin. But I can sell thee back to that Baptist and he can beat the tar out of thee."

Ten-year-old Billy was explaining to his 6-year-old brother that their Daddy was a mixture of English, Scotch, Irish, French and German. When 6-year-old failed to understand, Billy said, "If he was a dog you'd call him a mutt."

INSURE
RECEIVING YOUR
JOURNAL
WITHOUT INTERRUPTION
PAY YOUR DUES NOW

BUT DOCTOR I DIDN'T WASH THAT FOOT
JEST UNDRESS THE OTHER FOOT MRS. BILLBERG
THANX & A FLIP OF THE ULTRA SONIC TO DR CLARENCE O. AHO BRAINERD MINN.

Honesty pays:

A woman riding on a bus suddenly remembered she had not paid her fare. "Why bother," said her friend, "You got away with it." "Oh no," said the woman, "I always think honesty is the best policy." So she went up and paid. On her return she said, "See what I mean? I gave the driver a quarter and he gave me change for a half dollar."

The National Safety Council reports that its records fail to show a single accident in a tunnel of love. Still, it's a great place to enjoy the thrill of a *near miss.*

Definitions

Highbrow: One who can listen to the "William Tell Overture" without thinking of the "Lone Ranger."

Gentleman: A man who knows how to disagree without being disagreeable.

Washington Post and Times-Herald

A man was driving along a lonely road when he came upon a woman struggling with a flat tire. He stopped and changed the tire for her. As he picked up his tools the woman said, "Please let the jack down easy. My husband is asleep on the back seat."

Prairie Flower, Minot, N. D.

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"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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AMERICAN PODIATRY ASSOCIATION
(National Association of Chiropodists)
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Washington 10, D. C.

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The finest adhesive for felt, gauze, tape and moleskin

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FOR SALE: By estate of late Manchester, N. H. podiatrist. Practice established 5 years, first floor modern office in downtown area. Completely equipped including 2 hydros, X-ray, ultrasonic, etc. Terms will be considered. Write Mrs. Armand R. Brunelle, 111 West Merrimack Street, Manchester, N. H.

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LETS THE TOES BREATHE . . .

Slipped over the toes the bracelet creates a wider spread allowing free circulation of air to promote healing and dry "weeping" areas.

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